

## APPENDIX K. REPORTING REQUIREMENTS AND REPORTING DELIVERABLES

<b>Document Name</b>	MCO Reports Description
<b>Date Created</b>	September 4, 2011
<b>Last Revised</b>	<b>August 05, 2020</b>
<b>Owner</b>	Medicaid Managed Care Oversight Contract Management

Report#	Report Name	Status
1	NAIC Annual Financial Statement	Active
2	Audit/Internal Control	Active
3	NAIC Quarterly Financial Statement	Active
4	Executive Summary	Active
11	Call Center	Active
12A	Geo Access Network Reports and Maps	Active
13	Access and Delivery Network Narrative	Active
16	Summary of Quality Improvement Activities; Monitoring Indicators, Benchmarks and Outcomes	Active
17	Quality Assessment and Performance Improvement Work Plan; Utilization of Subpopulations and Individuals with Special Healthcare Needs	Active
21	MCO Committee Activity	Active
22	Satisfaction Survey(s)	Active
27	Grievance Activity	Active
28	Appeal Activity	Active
29	Grievances and Appeals Narrative	Active
38	Behavioral Health Services In/Out State Facility Utilization	Active
39	Monthly Formulary Management	Active
50A, 50B	Post Payment Billing Recovery	Active
51	Operational Changes	Active
52	Expenditures Related to MCO's Operations	Active
53	Prompt Payment	Active
54	COB Savings	Active
55	Medicare Cost Avoidance	Active
56	Non-Medicare Cost Avoidance	Active
57	Potential Subrogation	Active
58	Original Claims Processed	Active
59	Prior Authorizations	Active
60	Original Claims Inventory	Active
64	Monthly Benefit Payments	Active
65	Foster Care	Active
66	Guardianship	Active
68	Additions to Provider Network	Active
69	Termination from MCO Activity	Active
70	Denial of MCO Participation	Active
71	Provider Outstanding Accounts Receivables	Active
72	Member Violation Letters and Collections	Active
73	Explanation of Member Benefits (EOMB)	Active
74A	Medicaid Program Lock-In Reports/Admits Savings Summary Table	Active
74B	Medicaid Program Lock-In Reports/Rolling Annual Calendar Comparison	Active
74C	Medicaid Program Lock-In Reports/Member Initial Lock-In Effective Dates	Active
75	SUR Algorithms	Active
76	Provider Fraud Waste and Abuse	Active
77	Member Fraud Waste and Abuse	Active
78	Quarterly Benefits Payment	Active
79	Health Risk Assessments	Active
84	Quality Assessment and Performance Improvement Project Description	Active
85	Quality Improvement Plan and Evaluation	Active
86	Annual Outreach Plan	Active

90	Performance Improvement Projects Proposal	Active
91	Abortion Procedures	Active
92	Performance Improvement Projects Measurement	Active
93	EPSDT CMS – 416	Active
94	Member Surveys	Active
95	Provider Surveys	Active
96	Audited HEDIS Reports	Active
97	Behavioral Health Adults and Children Population	Active
119	Mental Health Statistics Improvement Project Adult Survey	Active
120	Youth Services Satisfaction Caregiver Survey	Active
126	Federally Qualified Health Centers	Active
127	Statement on Standards for Attestation Engagements (SSAE) No. 16	Active
173	MCO-PBM Compliance Report for POS Transactions	Active
200	834 RECONCILIATION REPORTS	Active
220	Newborn	Active
230	Capitation Payment Request	Active
250	Capitation Adjustment Requests	Active
251	Provider Credentialing Status Report	Active
252	IMD Report Institution for Mental Diseases 15 Days	Active
253	Substance Use Disorder (SUD) Inpatient and Residential Treatment	Active
300	Quarterly LRC Report	Active
301	Targeted Case Management Services	Active

Exhibit #	Exhibit Name		
Exhibit A	Billing Provider Type and Specialty Crosswalk		
Exhibit B	Billing Provider Type Category Crosswalk		
Exhibit C	Provider Enrollment Activity Reasons		
Exhibit D	Category of Service Crosswalk		
Exhibit E	EPSDT Category of Service Crosswalk		
Exhibit F	Medicaid Eligibility Group		
Exhibit G	Behavioral Health Population Definitions	Revised	12/15/15
Exhibit I	Mental Health Evidence Based Practices Definitions	Revised	07/29/13
Exhibit J	BHDID Psychotropic Medication Class Codes	Revised	07/29/13
Exhibit K	Behavioral Health and Chronic Physical Health	Revised	07/29/13

Report #:	1	Created:	09/10/2011
Name:	NAIC Annual Financial Statement	Last Revised:	09/24/2011
Group:	Finance and Medicaid Managed Care Oversight	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	January 1 through December 31		
Due Date:	Date Submitted to DOI		
Submit To:	Kentucky Department of Insurance Kentucky Department for Medicaid Services		

**Description:**

NAIC Financial Statement and Supplements are required by the Kentucky Department of Insurance (DOI). MCOs are required to comply with the DOI filing requirements. A copy of the NAIC Financial Statement and Supplements are required to be submitted to the Department for Medicaid Services (DMS) at the same time the reports are submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time. Due date for the Annual Financial Statement and Supplements is March 1 as stated in the DOI NAIC Checklist for Health.

Report #:	2	Created:	09/10/2011
Name:	Audit/Internal Control	Last Revised:	09/24/2011
Group:	Finance and Medicaid Managed Care Oversight	Report Status:	Active
Frequency:	Annual or as Appropriate	Exhibits:	NA
Period:	As Required by DOI		
Due Date:	Date Submitted to DOI		
Submit To:	Kentucky Department of Insurance Kentucky Department for Medicaid Services		

**Description:**

MCOs are required to comply with the Kentucky Department of Insurance (DOI) requirements for Audit/Internal Control reporting as referenced in the DOI NAIC Checklist for Health. A copy of the Audit/Internal Control reports are required to be submitted to the Department for Medicaid Services (DMS) at the same time the reports are submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time.

Report #:	3	Created:	09/10/2011
Name:	NAIC Quarterly Financial Statement	Last Revised:	09/24/2011
Group:	Finance and Medicaid Managed Care Oversight	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of the quarter through the last day of the quarter.		
Due Date:	Date Submitted to DOI		
Submit To:	Kentucky Department of Insurance Kentucky Department for Medicaid Services		

**Description:**

NAIC Quarterly Financial Statement and Supplements are required by the Kentucky Department of Insurance (DOI). MCOs are required to comply with the DOI filing requirements. A copy of the NAIC Quarterly Financial Statement and Supplements are required to be submitted to the Department for Medicaid Services (DMS) at the same time the reports are submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time. Due dates for the Quarterly Financial Statement and Supplements are May 15, August 15 and November 15 as stated in the DOI NAIC Checklist for Health.

Report #:	4	Created:	12/12/2011
Name:	Executive Summary	Last Revised:	
Group:	Executive Summary	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Provide a narrative overview summarizing significant activities during the reporting period, problems or issues during the reporting period, and any program modifications that occurred during the reporting period. The overview should also contain success stories or positive results that were achieved during the reporting period, any specific problem area that the MCO plans to address in the future, and a summary of all press releases and issues covered by the press.

**Sample Layout:**

Kentucky Department for Medicaid Services  
MCO Report # 4: Executive Summary

MCO Name:	<b>DMS Use Only</b>
Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

- I. **Significant Operational Activities**
  - A. Overview of Success Stories and Positive Results
  - B. Problems or Issues Identified
  - C. Other Plan Activities
- II. **Summary of Reports**
  - A. Eligibility and Enrollment;
  - B. Access/Delivery Network
  - C. Quality Assurance/Performance Improvement(QAPI)
  - D. Grievance/Appeals
  - E. Budget Neutrality
  - F. Utilization
  - G. Systems
  - H. Other Plan Activities
- III. **Summary of Media/Press Releases**

Media Source	Name	Date	Title-Subject	Highlight-Overview

Report #:	11	Created:	08/27/2011
Name:	Call Center	Last Revised:	09/01/2011
Group:	Member Services and Quality	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Provides MCO reporting of call center performance in the areas of abandonment, blockage rate and average speed of answer. A total for all Splits/VDN and each individual Split/VDN is to be reported.

**Sample Layout:**

Member (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Behavioral Health (Main/Trunk)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Provider (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

Medical Advice (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

<List Other by Name> (Main/Trunk Line)	Total all Incoming Calls/VDN	<name of Split 1>	<name of Split 2>	<name of Split 3>	<name of Split #>
	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy	mm/yyyy
Number of Calls					
Number of Calls Abandoned					
% Abandoned Calls					
Average Speed to Answer (seconds)					

**ReportingCriteria:**

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
<List Other by Name>	The report is to include all Main/Trunk lines that the MCO or the MCO subcontractors maintain. Additional sections of the report are to be added as needed.

Row Label	Description
Number of Calls	Number of calls received including answered, abandoned and blocked.
Number of Calls Abandoned	Calls into the call centers that are terminated by the persons originating the call before answer by a staff person. (URAC standards measure this as the calls that disconnect after 30 seconds when a live individual would have answered the call. If there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended).
% Abandoned Calls	The percentage of calls into the call center that are terminated by the persons originating the call before answer by a staff person. (URAC standards measure this as the percentage of calls that disconnect after 30 seconds when a live individual would have answered the call. If there is a pre-recorded message or greeting for the caller, the 30-second measurement begins after the message/greeting has ended)

Average Speed to Answer (seconds)	The average delay in seconds that inbound telephone calls encounter waiting in the telephone queue of a call center before answer by a staff person (URAC measures the speed of answer starting at the point when a live individual would have answered the call. If there is a pre-recorded message or greeting for the caller, the time it takes to respond to the call – average speed of answer – begins after the message/greeting has ended).
Highest Maximum Delay (minutes)	The one call during the reporting period that had the greatest delay in speed to answer measured in minutes.
% Calls Answered on or before 4th Ring	The percentage of calls answered on or before the fourth ring.
% Calls Receiving Busy Signal	The percentage of incoming telephone calls 'blocked' or not completed because switching or transmission capacity is unavailable, as compared to the total number of calls encountered. Blocked calls usually occur during peak call volume periods and result in callers receiving a busy signal.
% Calls Answered within 30 Seconds	The percentage of calls answered within thirty seconds.
Average Length of Call (minutes)	The average length of all calls answered measured in minutes.

<u>Column Label</u>	<u>Description</u>
<u>Total All Incoming Calls/VDN</u>	<u>Report a total for all incoming calls to the Main/Trunk line.</u>
<u>&lt;name of split&gt;</u>	<u>A separate column needs to be added to the report for each individual Split/VDN maintained for the Main/Trunk line.</u>
<u>mm/yyyy</u>	<u>The reporting period represented by a two character number for the month (mm) and a four character number for the year (yyyy). Example: January 2012 would be represented as 01/2012.</u>

Report#:	12A	Created:	02/06/2012
Name:	Geo Access Network Reports and Maps	Last Revised:	
Group:	Access/Delivery Network	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	Ongoing		
Due Date:	July 31st		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

MCO's should provide the GEO Access Network Reports and Maps on an annual basis or upon request by the Department.

**Sample Layout:**

Title page, table of contents, accessibility standard comparison, accessibility standard detail, accessibility detail, accessibility summary, member map, provider listing, provider map, service area detail.

Maps shall include geographic detail including highways, major streets and the boundaries of the MCO's network. In addition to the maps and charts, the MCO shall provide an analysis of the capacity to serve all categories of Members. The analysis shall address the standards for access to care. Maps shall include the location of all categories of Providers or provider sites as follows:

- A. Primary Care Providers (designated by a "P");
- B. Primary Care Centers, non FQHC and RHC (designated by a "C");
- C. Dentists (designated by a "D");
- D. Other Specialty Providers (designated by a "S");
- E. Non-Physician Providers - including nurse practitioners, (designated by a "N") nurse mid-wives (designated by a "M") and physician assistants (designated by a "A");
- F. Hospitals (designated by a "H");
- G. After hours Urgent Care Centers (designated by a "U");
- H. Local health departments (designated by a "L");
- I. Federally Qualified Health Centers/Rural Health Clinics (designated by a "F" or "R" respectively);
- J. Pharmacies (designated by a "X");
- K. Family Planning Clinics (designated by an "Z");
- L. Significant traditional Providers (designated by an "\*");
- M. Maternity Care Physicians (designated by a "O");
- N. Vision Providers (designated by a "V"); and
- O. Community Mental Health Centers (designated by an "M").

Report#:	13	Created:	02/06/2012
Name:	Access and Delivery Network Narrative	Last Revised:	
Group:	Access/Delivery Network	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:** MCOs should provide specific information on Access Issues/Problems Identified on the nature of any access problems identified and any plans or remedial action taken.

**Sample Layout:**

Kentucky Department for Medicaid Services  
MCO Report # 13: Access and Delivery Network Narrative  
MCO Name:

**DMS Use Only**

Report Date: Received Date:  
Report Period From: Reviewed Date:  
Report Period To: Reviewer:

1. Summary of Complaints - Access Issues
  - A. Provider
  - B. Member
2. Network Access Problems
  - A. Issue
  - B. Remedial Action Taken

Report #:	16	Created:	12/12/2011
Name:	Summary of Quality Improvement Activities; Monitoring Indicators,	Last Revised:	06/15/18
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	State Fiscal Year: 01-JULY through 30-JUNE		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:** Describe the quality assurance activities during the report period directed at improving the availability, continuity, and quality of services. Examples include problems identified from utilization review to be investigated, medical management committee recommendations based on findings, special research into suspected problems and research into practice guidelines or disease management. Include a narrative on the MCO's progress in developing or obtaining baseline data and the required health outcomes, including proposed sampling methods and methods to validate data, to be used as a progress comparison for the Contractor's quality improvement plan. The report should include how the baseline data for comparison will be obtained or developed and what indicators of quality will be used to determine if the desired outcomes are achieved.

**Sample Layout:**

Kentucky Department for Medicaid Services  
MCO Report # 16: Summary of Quality Improvement Activities; Monitoring Indicators, Benchmarks and Outcomes  
MCO Name: **DMS Use Only**

Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

**MCO completed the following activities during the year:**

- A. Improving Availability
- B. Continuity
- C. Quality of Services
- D. Monitoring
- E. Benchmarks
- F. Outcome

Report #:	17	Created:	01/09/2012
Name:	Quality Assessment and Performance Improvement Work Plan; Utilization of Subpopulations	Last Revised:	06/15/2018
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The MCO shall have a written Quality Assessment and Performance Improvement Work Plan (QAPI) Work Plan that outlines the scope of activities and the goals, objectives and timelines for the QAPI program. New goals and objectives must be set at least annually based on findings from quality improvement activities and studies, survey results, Grievances and Appeals, performance measures and EQRO findings. The MCO is accountable to the Department for the quality of care provided to Members. The Contractor's responsibilities of this include, at a minimum: approval of the overall QAPI program and annual QAPI work plan; designation of an accountable entity within the organization to provide direct oversight of QAPI; review of written reports from the designated entity on a periodic basis, which shall include a description of QAPI activities, progress on objectives, and improvements made; review on an annual basis of the QAPI program; and modifications to the QAPI program on an ongoing basis to accommodate review findings and issues of concern within the organization. Discuss any issues that arose during the report period that related to persons associated with sub-populations and individuals with special healthcare needs. Examples of sup-populations and individuals with special health care needs include members with chronic and disabling conditions, minorities, children enrolled with the Commission for Children with Special Health Care Needs, persons receiving SSI, persons with mental illness, the disabled, homeless, and any groups identified by the Contractor for targeted study. Discuss progress in the development of new or ongoing outreach and education to these special populations.

**Sample Layout:**

Kentucky Department for Medicaid Services  
MCO Report # 17: Quality Assessment and Performance Improvement Work Plan; Utilization of Subpopulations and Individuals with Special Healthcare Needs

MCO Name: **DMS Use Only**

Report Date: Received Date:  
Report Period From: Reviewed Date:  
Report Period To: Reviewer:

**Quality Improvement**

- A. Improving Availability
- B. Continuity
- C. Quality of Services

**Following Outreach/Education to Special Populations (population examples):**

- A. Children with Special Healthcare Needs
- B. Activities Related to the Homeless Population
- C. Foster Care/Out of Home Placement
- D. Guardianship
- E. Smoking Cessation
- F. COPD
- G. Asthma
- H. Diabetes
- I. EPSDT

Report#:	21	Created:	01/13/2012
Name:	MCO Committee Activities	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Provide a summary of the any MCO committee activities that met during the reporting period, including changes to the committee structure, if any, and any decisions regarding quality and appropriateness of care. Provide copies of meeting minutes and reports of any special focus groups.

Kentucky Department for Medicaid Services MCO Report # 21: MCO Committee Activities

MCO Name: **DMS Use Only**  
 Report Date: Received Date:  
 Report Period From: Reviewed Date:  
 Report Period To: Reviewer:

**I. Quality and Member Access Committee**

- A. Committee Structure
- B. Committee Decisions (quality and appropriateness of care)
- C. Provide list of members on committee

**II. Committee Name**

- A. Committee Structure
- B. Committee Decisions (quality and appropriateness of care)
- C. Provide list of members on committee

**III. Committee Name**

- A. Committee Structure
- B. Committee Decisions (quality and appropriateness of care)
- C. Provide list of members on committee

Report#:	22	Created:	01/09/2012
Name:	Satisfaction Survey(s)	Last Revised:	
Group:	Quality Assurance and Improvement	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:** Describe results of any satisfaction survey that was conducted by the MCO during the report period, if applicable.

(Note: surveys CAHPS are conducted each year, so this section will be completed one quarter for the providers and one for the members) at a minimum.

**Sample Layout:**

Kentucky Department for Medicaid Services MCO Report # 22: Satisfaction Survey(s)

MCO Name: **DMS Use Only**  
 Report Date: Received Date:  
 Report Period From: Reviewed Date:  
 Report Period To: Reviewer:

**I. Satisfaction Survey**

- A. Population Surveyed
- B. Results

Report#:	27	Created:	08/27/2011
Name:	Grievance Activity	Last Revised:	03/01/2015
Group:	Grievance and Appeals	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of the quarter through the last day of the quarter		
Due Date:	By 30 calendar days following the last day of the reporting period		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Report provides summarized activity for both Member Grievances and Provider Grievances voiced to the MCO during the reporting period. Grievance means the definition established in 42 CFR 438.400. MCOs are to report:

All Grievances received during the reporting period;

All Grievances received in prior periods that are resolved in the reporting period; All Grievances received in prior periods that have not been resolved.

**Sample Layout:**

Medicaid ID	Date Grievance Received	Date Acknowledgement Letter Sent	Reason for Grievance	Pending	14 Day Extension Granted	Date Extension Letter Sent	Date Completed	Number of Days Open	Grievance Resolved	Date Resolution Letter Sent	Timely Resolution	Reason Late/Comments

Provider NPI Provider ID	Date Grievance Received	Date Acknowledgement Letter Sent	Reason for Grievance	Pending	14 Day Extension Granted	Date Extension Letter Sent	Date Completed	Number of Days Open	Grievance Resolved	Date Resolution Letter Sent	Timely Resolution	Reason Late/Comments

**Reporting Criteria:**

Terminology	Definition
Date Format	All report dates not otherwise specified are to be in the following format: yyyy/mm/dd.

Row Label	Description
NA	NA

Column Label	Description
Member	Member initiated grievances are to be reported under the Member Tab
Provider	Provider initiated grievances are to be reported under the Provider Tab.
Medicaid ID	Member's Medicaid Identification Number
NPI	National Provider's Identification Number. Atypical Providers use their Kentucky Provider's Medicaid Identification Number.
Date Grievance Received	Date grievance received by MCO
Date Acknowledgement Letter Sent	Date MCO mailed grievant written acknowledgment letter.
Reason for Grievance	List the specific issue of dissatisfaction the grievant voiced. If a grievance includes more than one issue then report each issue separately as an individual grievance.
Pending	Grievances that are not resolved within the reporting period are carried over to the next reporting period as "pending". Valid values are "yes" or "no."
14 Day Extension Granted	Indicate if the MCO granted a 14 calendar day extension, at the request of the grievant or at the decision of the MCO. Valid values are "yes," "no" or "N/A."
Date Extension Letter Sent	Date MCO mailed grievant written extension letter.
Date Grievance Resolved	Date grievance is resolved by the MCO. Valid values are "date" or "N/A."

Number of Days Open	Total number of calendar days the grievance is opened. For a grievance that is pending, it is measured as date grievance received to the end of the reporting period. For a resolved grievance, it is measured as date grievance received through date grievance is resolved.
Grievance Resolved	Grievance status on the last day of the reporting period.
Date Resolution Letter Sent	Date MCO mailed grievant written resolution letter.
Timely Resolution	Grievances resolved over 30 calendar days or in 44 days if an extension has been granted. Valid values are "yes," "no" or "N/A."
Reason Late/Comments	MCO explanation for delayed resolution. MCO Comments.

Report #:	28	Created:	08/27/2011
Name:	Appeal Activity	Last Revised:	10/12/2011
Group:	Member and Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	A, B, D
Period:	First day of the quarter through the last day of the quarter		
Due Date:	By 30 calendar days following the last day of the reporting period		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Report provides a summarized activity for both Member and Provider Appeals during the reporting period. Member appeals are based on Category of Service (COS) while Provider Appeals are based on Billing Provider Type/Category.

Two (2) Billing Provider Types are further broken down as follows:

1. BillingProviderType01GeneralHospital
  - a. Inpatient;
  - b. Outpatient;
  - c. Emergency Room; and
  - d. Inpatient/Outpatient Other
2. Billing Provider Type 54 Pharmacy
  - a. Pharmacy non-Behavioral Health Brand;
  - b. Pharmacy non-Behavioral Health Generic;
  - c. PharmacyBehavioralHealthBrand;and
  - d. Pharmacy Behavioral Health Generic

An appeal submitted by a Provider on the Member’s behalf is to be reported under Member Appeal Activity.

**Sample Layout:**

**Member Appeal Activity**

COS	Category of Service (COS) Description	Beginning Balance	Ending Balance **
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**Member Appeal Activity**

Received					
Total	Expedited		Non Expedited		
	Oral	Written	Oral	Written	5 Working Days Written Notice Provided

# Resolved

Total	Expedite Resolved in 3 Working Days	Non Expedited Resolved in 30 Calendar Days *	Non Expedited Average Days for Resolution	Written Notice of Resolution within 30 Calendar Days *
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# Resolved

								Appeals Extended by 14 Calendar Days
Expedited				Non Expedited				
Final Disposition			Moved to Non Expedited	Oral Abandoned	Final Disposition			
Upheld	Overtured	Partially Overtured			Upheld	Overtured	Partially Overtured	

## Medicaid Mandatory Services

02	Inpatient Hospital	0	0
12	Outpatient Hospital	0	0
32	EPSDT Related	0	0
34	Clinical Social Worker	0	0
37	Physical Therapist Crossover	0	0
38	Occupational Therapist	0	0
39	Psychologist Crossover	0	0
40	DME	0	0
41	Primary Care	0	0
43	Rural Health Clinic	0	0
44	Nurse Midwife	0	0
45	Family Planning	0	0
46	Home Health	0	0
47	Independent Laboratory	0	0
48	EPSDT Preventive	0	0
62	Emergency Transportation	0	0
63	Non-Emergency Transportation	0	0
67	Vision	0	0
72	Dental	0	0
74	Physician	0	0
75	Certified Nurse Practitioner	0	0

81	Hearing	0	0
90	Comp. Outpatient Rehab Facility	0	0
92	Psychiatric Distinct Part Unit	0	0
93	Rehab Distinct Part Unit	0	0
94	Physician Assistant	0	0
	Subtotal: Mandatory Services		

#### Medicaid Optional Services

03	Mental Hospital	0	0
04	Renal Dialysis Clinic	0	0
08	Psychiatric Residential Treat Facility	0	0
13	Ambulatory Surgery	0	0
16	Impact Plus	0	0
17	Specialized Children's Services Clinic	0	0
20	Targeted Case Management – Adults	0	0
21	Targeted Case Management – Children	0	0
24	Comm. for Child Special Health Needs	0	0
29	Preventive Health	0	0
35	Chiropractor	0	0
36	Other Lab & X-Ray	0	0
42	Community Mental Health Center	0	0
54	Nurse Anesthetist	0	0
55	Hospice – Non Institutional	0	0
64	Pharmacy	0	0
88	Podiatry	0	0
99	Unknown Type	0	0
	Subtotal: Optional Services		
	Total: Mandatory and Optional		

Provider Type/Category	Provider Appeal Activity													
	Beginning Balance	Ending Balance	Received				Resolved							Appeals Extended by 14 Calendar Days
			Total	Oral	Written	5 Working Days Written Notice	Total	Resolved in 30 Calendar Days	Average Days for Resolution	Written Notice of Resolution	Oral Abandoned	Upheld	Overtured	Partially Overtured

Inpatient															
Outpatient															
Unknown Type															
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

**Reporting Criteria:**

Terminology	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
COS	Two character designation for a state specific category of service. Crosswalk may be found in Exhibit D.
Category of Service (COS) Description	A description for the 'COS'.
Medicaid Mandatory Services	State covered Medicaid services required by federal law.
Subtotal: Mandatory Services	Calculated field. Sum total of all services listed as mandatory services. For columns with Average Days it is the average days of resolution for all mandatory services.
Medicaid Optional Services	State covered Medicaid services in addition to the mandatory covered services the state has chosen to cover.
Subtotal: Optional Services	Calculated field. Sum total of all services listed as optional services. For columns with Average Days it is the average days of resolution for all optional services.
Total: Mandatory and Optional	Calculated field. Total of all mandatory and optional services. For columns with Average Days it is the average days of resolution for all mandatory and optional services.
Provider Type/Category	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk. Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Total	Calculated field. Total of all Provider Type/Category listed in the report. For columns with Average Days it is the average days of resolution for all Provider Type/Category listed in the report.

Column Label	Description
Member: Beginning Balance	Total number of outstanding appeals at the beginning of the first day of the reporting period.
Member: Ending Balance	Total number of outstanding appeals at the end of the last day of the reporting period.

Member: Received: Total	Total number of appeals received during the reporting period.
Member: Received: Expedited	Total number of expedited appeals received within the reporting period broken down by Oral and Written.
Member: Received: Expedited: Oral	Total number of expedited oral appeals received within the reporting period.
Member: Received: Expedited: Written	Total number of expedited written appeals received within the reporting period.
Member: Received: Non Expedited	Total number of non-expedited appeals received within the reporting period broken down by Oral and Written.
Member: Received: Non Expedited: Oral	Total number of non-expedited oral appeals received within the reporting period.
Member: Received: Non Expedited: Written	Total number of non-expedited written appeals received within the reporting period.
Member: Received: Non Expedited: 5 Working Days Written Notice Provided	Total number of written notices provided within five (5) working days for non-expedited appeals.
Member: Resolved: Total	Total number of appeals resolved during the reporting period.
Member: Resolved: Expedited Resolved in 3 Working Days	Total of expedited appeals resolved in three (3) or fewer working days.
Member: Resolved: Non Expedited Resolved in 30 Calendar Days	Total of non-expedited appeals resolved in thirty (30) or fewer calendar days.
Member: Resolved: Non Expedited	Average number of days to resolve all non-expedited appeals excluding non-

Average Days for Resolution	expedited appeals extended by fourteen (14) calendar days.
Member: Resolved: Written Notice of Resolution within 30 Calendar Days	Total number of written notice of resolution that were provided within thirty (30) calendar days of receipt of a non-expedited appeal.
Member: Resolved: Expedited	An appeal that is required to be resolved within three (3) calendar days).
Member: Resolved: Final Disposition	Result of the expedited or non-expedited appeal process broken down by upheld, overturned and partially overturned.
Member: Resolved: Expedited: Final Disposition: Upheld	Total number of expedited appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.
Member: Resolved: Expedited: Final disposition: Overturned	Total number of expedited appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Member: resolved: Expedited: Final disposition: Partially Overturned	Total number of expedited appeals that were resolved during the reporting period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Member: Resolved: Expedited: Moved to Non Expedited	Number of expedited appeals that moved to a non-expedited appeal process.
Member: Resolved: Non Expedited: Oral Abandoned	A non-expedited appeal that was not followed up by a written appeal and no additional action was taken.
Member: Resolved: Non Expedited: Final Disposition: Upheld	Total number of non-expedited appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.
Member: Resolved: Non Expedited: Final Disposition: Overturned	Total number of non-expedited appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Member: Resolved: Non Expedited: Final Disposition: Partially Overturned	Total number of non-expedited appeals that were resolved during the reporting period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Member: Appeals Extended by 14 Calendar Days	The total number of non-expedited appeals that were extended by fourteen (14) calendar days beyond the initial thirty (30) calendars day period.
Provider: Beginning Balance	Total number of outstanding appeals at the beginning of the first day of the reporting period.
Provider: Ending Balance	Total number of outstanding appeals at the end of the last day of the reporting period.
Provider: Received: Total	Total number of appeals received during the reporting period.
Provider: Received: Oral	Total number of oral appeals received within the reporting period.
Provider: Received: Written	Total number of written appeals received within the reporting period.

Provider: Received: 5 Working Days Written Notice Provided	Total number of written notices provided within five (5) working days.
Provider: Resolved: Total	Total number of appeals resolved during the reporting period.
Provider: Resolved: Resolved in 30 Calendar Days	Total number of appeals resolved in thirty (30) or fewer calendar days.
Provider: Resolved: Average Days for Resolution	Average number of days to resolve all appeals excluding appeals extended by fourteen (14) calendar days.
Provider: Resolved: Written Notice of Resolution within 30 Calendar Days	Total number of written notice of resolution that were provided within thirty (30) calendar days of receipt of a non-expedited appeal.
Provider: Resolved: Oral Abandoned	An oral appeal that was not followed up by a written appeal and no additional action was taken.
Provider: Resolved: Upheld	Total number of appeals that were resolved during the reporting period and were upheld. Upheld means that the prior decision was confirmed and remains as is.

Provider: Resolved: Overturned	Total number of appeals that were resolved during the reporting period and were overturned. Overturned means that the prior decision was not confirmed and was reversed.
Provider: Resolved: Partially Overturned	Total number of appeals that were resolved during the reporting period and were partially overturned. Partially overturned means that part of the prior decision was not confirmed and was reversed.
Provider: Appeals Extended by 14 Calendar Days	The total number of appeals that were extended by fourteen (14) calendar days beyond the initial thirty (30) calendar day period.

Report#:	29	Created:	02/06/2012
Name:	Grievances and Appeals Narrative	Last Revised:	
Group:	Grievances and Appeals	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Discuss any trends or problem areas identified in the appeals and grievance and address opportunity for improvement.

**Sample Layout:**

Kentucky Department for Medicaid Services  
MCO Report #29: Grievances and Appeals Narrative

MCO Name:	<b>DMS Use Only</b>
Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

**Member Grievances**

Trends  
Problems or Issues Identified  
Opportunity for Improvement

**Provider Grievances**

Trends  
Problems or Issues Identified  
Opportunity for Improvement

### Member Appeals

Trends  
Problems or Issues Identified  
Opportunity for Improvement

### Provider Appeals

Trends  
Problems or Issues Identified  
Opportunity for Improvement

Report #:	38	Created:	01/22/2019
Name:	Behavioral Health Services In/Out State Facility Utilization	Last Revised:	
Group:	Utilization	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>h</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

### Description:

MCO should provide Special Services. Report will contain Behavioral Health services placement information for members. This report should identify in and out of state BH facility utilization for all members under age 21. The report should include ALL members under age 21 that are in a facility for 10 days or more in and out of the state of KY for a BH service no matter what service they are receiving. If the member is in a facility and receiving an EPSDT Special Service, it should be reported.

### Reporting Criteria:

General Specifications	Definition
Sort Order	The report is to be sorted in order: Facility Name (A to Z); Member last name (A to Z).

Column Label	Description
Member Last Name	The Member's last name
Member First Name	The Member's first name
Member Medicaid ID	The Member's Medicaid ID number
Facility NPI Number	The Facility's NPI number
Facility Name	The complete name of the facility
Facility State	The 2 digit postal abbreviation of the state where the facility is located
Level of Care	The amount of assistance a member requires to meet their needs. Examples: Inpatient, PRTF, ECU, Substance Abuse
Date of Admission	The date the member was admitted. Use mm/dd/yyyy
Admitting Diagnosis	The primary diagnosis
Foster Care Indicator	The member's foster care status. Acceptable entries are Y and N
Date of Last Review	The date of the last review to determine continuation of current services. Use mm/dd/yyyy
Discharge Date	The date the member was/is to be discharged from the current level of care. If unknown, leave blank.
Discharge Disposition	The code for anticipated placement when the Member is discharged from the current level of care. Acceptable entries are: 1 - Bio Home; 2 - Foster Parents; 3 - PRTF/Residential; 4 - AMA; 5 - TFC (Therapeutic Foster Care); 6 - CSU (Crisis Stabilization Unit); 7 - ECU (Extended Care Unit); 8 Continues Inpatient
Aftercare	The type of facility providing care after discharge. Acceptable entries are: 1 - PRTF; 2 - Residential; 3 - Outpatient CMHC; 4 - Outpatient Non-CHMC; 5 - None; 6-DCBS Placement
Date of De-Certification	The date the member was/is to be De-Certification from the current level of care. If unknown, leave blank

Facilities Discharge Recommended Level of Care	The Facilities Discharge Recommended Level of Care
Appeal Filed by Agency=Yes or No; Results of Appeal	Yes or No to Appeal Filed by Agency; If Yes the results of the appeal

Sample Layout:

Member Last Name	Member First Name	Member Medicaid #	Facility NPI #	Facility Name	Facility State	Level of Care	Date of Admission	Admitting Diagnosis	Foster Care Status	Date of Last Review	Discharge Date	Discharge Disposition	Aftercare	Date of De-Certification	Facilities Discharge Recommended Level of Care	Appeal Filed by Agency=Yes or No; Results of Appeal
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Report#:	39	Created:	01/04/2012
Name:	Monthly Formulary Management Report	Last Revised:	02/07/2012
Group:	Pharmacy	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

#### Description:

Monthly summary of pharmacy related utilization and costs by Medicaid members assigned to Managed Care Organizations broken down by region.

Sample Layout:

		NOV-11	DEC-11	JAN-12	%CHANGE PER MONTH	%CHANGE PER YEAR	AVERAGE PER MONTH	Y-T-D
STATIST	NEWRXS							
	REFILLRXS							

	TOTAL NON PDL RXS							
	% NON PDL RXS							
	PSYCH RXS							
	% PSYCH RXS							
	NON PDL PSYCH RXS							
	% NON PDL PSYCH RXS							

	# PSYCH UTILIZERS							
	% PSYCH UTILIZERS							
	% PSYCH UTILIZERS/RX UTILIZERS							
	# PSYCH RXS/MEMBER							
	# PSYCH RXS/PSYCH UTILIZER							
	#RXS/MEMBER LESSPSYCHS							
	%MEMBERSON MEDSLESS PSYCHS							
	PSYCH COST/PSYCH UTILIZER							
	# PROVIDER PRESCRIBED OTCS							
	#CONTROLLED RXS							
	%BRAND							
	%GENERIC							
BEHAVIORAL HEALTH	% ATYP ANTIPSYCH UTILIZERS							
	%MEMBERSON ATYP ANTIPSYCHS/RX UTILIZERS							
	# TYPICAL ANTIPSYCH UTILIZERS							
	% TYPICAL							
	ANTIPSYCH UTILIZERS							
	#MEMBERSON ATYP TO TYP							
	BH% BRAND							
	BH% GENERIC							
PERCENTAGES	% PDL COST/TOTAL COST							
	% NON PDL COST/TOTAL COST							
	% PSYCH COST/TOTAL COST							

	% PDL PSYCH COST/TOTAL COST							
	% NON PDL PSYCH COST/TOTAL COST							
	% ATYP ANTIPSYCH COST/TOTAL COST							
	% HIV COST/TOTAL COST							
	% HEP B COST/TOTAL COST							
	% HEP C COST/TOTAL COST							
SPECIALTY	HEP C RXS							
	# HEP C UTILIZERS							
	HEP C RX COST							
	HEP C COST/HEP C UTILIZER							
	HEP B RXS							
	# HEP B UTILIZERS							
	HEP B RX COST							
	HEP B COST/HEP B UTILIZER							

	HEP B COST/MEMBER							
	HIV RXS							
	# HIV UTILIZER							
	HIV RX COST							
	HIV COST/HIV UTILIZER							
COST	TOTAL COST							
	DRUG REIMBURSEMENT							
	DISPENSING FEES							
	TOTAL COST/MEMBER							
	COST/RX UTILIZER							
	PDL TOTAL COST							
	PDL COST/MEMBER							
	NON PDL TOTAL COST							

	NON PDL COST/MEMBER							
	PSYCHCOST							
	PSYCH COST/MEMBER							
	PDL PSYCH COST							
	PDL PSYCH COST/MEMBER							
	NONPDL PSYCH COST							
	NONPDL PSYCH COST/MEMBER							
	ATYPANTIPSY COST							
	ATYPANTIPSY COST/MEMBER							
	ATYPANTIPSYCH COST/ATYP ANTIPSYUTILIZER							
	PROVIDER PRESCRIBEDOTC TOTAL COST							
	PROVIDER PRESCRIBEDOTC COST/MEMBER							
	TOTALINSULIN COST							

	PROVIDER PRESCRIBEDOTC COST LESS INSULIN							
	H2BLOCKERS TOTALCOST							
	NSAIDSTOTAL COST							
	PPI TOTAL COST							
	VACCINETOTAL COST							
TOTAL REGIONS	# MEMBERS							
	% UTILIZERS							
	# RXS							
	AVG # RXS/MEMBER							
	AVG # RXS/UTILIZER							
	# PAs							
	% PAs DENIED							
	# CLAIMS							
	% CLAIMS DENIED							
	# PRESCRIBERS							

	#							
	RXS/PRESCRIBER							
	#CONTROLS/ PRESCRIBER							
	#PHARMACIES							
	AVGCOST/RX							
	SUBOXONERXS							
	ADHDRXS							
REGION 1	LOCK INS							
	#MEMBERS							
	%UTILIZERS							
	# RXS							
	AVG #							
	RXS/MEMBER							
	AVG #							
	RXS/UTILIZER							
	# PAs							
	%PAs DENIED							
	#CLAIMS							
	%CLAIMS DENIED							

	#PRESCRIBERS							
	#							
	RXS/PRESCRIBER							
	#CONTROLS/ PRESCRIBER							
	#PHARMACIES							
	AVG COST/RX							
	SUBOXONERXS							
	ADHD RXS							

Reporting Criteria:

Terminology	Definition
DateFormat	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Definition
NEWRXS	Number of new prescriptions
REFILLRXS	Number of refill prescriptions
TOTAL NON PDL RXS	Total number of prescriptions written for a drug not listed on the preferred drug list
% NON PDL RXS	Percentage of prescriptions written for a drug not listed on the preferred drug list
PSYCH RXS	Number of prescriptions written for a psychotropic drug
% PSYCH RXS	Percentage of prescriptions written for a drug not listed on the preferred drug list
NON PDL PSYCHRXS	Number of prescriptions written for a psychotropic drug not listed on the preferred drug list
% NON PDL PSYCH RXS	Percentage of prescriptions written for a psychotropic drug not listed on the preferred drug list
# PSYCH UTILIZERS	Number of Medicaid/MCO members for whom psychotropic drug prescriptions were filled
% PSYCH UTILIZERS	Percentage of Medicaid/MCO members for whom psychotropic drug prescriptions were filled
% PSYCH UTILIZERS/RX UTILIZERS	Percentage of Medicaid/MCO members for whom psychotropic drug prescriptions were filled as compared to total Medicaid/MCO members for whom any drug prescriptions were filled
#PSYCH RXS/MEMBER	Number of psychotropic prescriptions per Medicaid/MCO member

# PSYCH RXS/PSYCH UTILIZER	Number of psychotropic prescriptions per Medicaid/MCO member who fills prescriptions written for psychotropic medications
#RXS/MEMBER LESSPSYCHS	Number of prescriptions per Medicaid/MCO member not counting prescriptions for psychotropic medications
%MEMBERSON MEDSLESS PSYCHS	Percentage of Medicaid/MCO members for whom drug prescriptions were filled not counting prescriptions for psychotropic medications
PSYCHCOST/PSYCH UTILIZER	Psychotropic drug cost/Medicaid/MCO member for whom psychotropic medication were filled
# OTC RXS	Number of prescriptions filled for over the counter items
#CONTROLLEDRXS	Number of prescriptions filled for controlled (scheduled) narcotics
% BRAND	Percentage of prescriptions filled with brand name drugs
%GENERIC	Percentage of prescriptions filled with a generic drug
ATYPANTIPSYCH	Number of prescriptions filled for an atypical anti-psychotropic drug

RXS	
NON PDLATYPANTI PSYCH RXS	Number of prescriptions filled for an atypical anti-psychotropic drug not listed on the preferred drug list
#ATYPANTIPSYCH UTILIZERS	Number of Medicaid/MCO members for whom drug prescriptions for atypical antipsychotics were filled
% ATYPANTIPSYCH UTILIZERS	Percentage of Medicaid/MCO members for whom drug prescriptions were filled for atypical antipsychotics
%MEMBERSON ATYP ANTIPSYCHS/RX UTILIZERS	Percentage of Medicaid/MCO members for whom drug prescriptions were filled for atypical antipsychotics as compared to total Medicaid/MCO members for whom any drug prescriptions were filled
# TYPICAL ANTIPSYCH UTILIZERS	Number of Medicaid/MCO members for whom drug prescriptions for typical antipsychotics were filled
% TYPICAL ANTIPSYCH UTILIZERS	Percentage of Medicaid/MCO members for whom drug prescriptions for typical antipsychotics were filled
BH% BRAND	Percentage of behavioral health prescriptions filled with a brand name drug
BH% GENERIC	Percentage of behavioral health prescriptions filled with a generic drug
%PDL COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs on the preferred drug list as compared with total drug cost
%NON PDL COST/TOTALCOST	Percentage of drug cost for prescriptions filled with drugs on the non-preferred drug list as compared with total drug cost
%PSYCH COST/TOTALCOST	Percentage of drug cost for prescriptions filled with psychotropic drugs as compared with total drug cost
%PDL PSYCH COST/TOTALCOST	Percentage of drug cost for prescriptions filled with drugs on the preferred drug list as compared with total drug cost
%NON PDL PSYCH COST/TOTALCOST	Percentage of drug cost for prescriptions filled with drugs not on the preferred drug list as compared with total drug cost
% ATYP ANTIPSYCH COST/TOTALCOST	Percentage of drug cost for prescriptions filled with atypical antipsychotic drugs as compared with total drug cost
%HIV COST/TOTAL COST	Percentage of drug cost for prescriptions filled with drugs used to treat HIV as compared with total drug cost

<b>% HEP B COST/TOTALCOST</b>	Percentage of drug cost for prescriptions filled with drugs used to treat Hep B as compared with total drug cost
<b>% HEP C COST/TOTALCOST</b>	Percentage of drug cost for prescriptions filled with drugs used to treat Hep C as compared with total drug cost
<b>HEP C RXS</b>	Number of prescriptions filled with drugs used to treat Hep C
<b># HEP C UTILIZERS</b>	Number of Medicaid/MCO members for whom prescriptions for drugs used to treat Hep C are filled
<b>HEP C RX COST</b>	Total cost for prescriptions filled with drugs used to treat Hep C
<b>HEP C COST/HEP C UTILIZER</b>	Cost for prescriptions filled with drugs used to treat Hep C per Medicaid/MCO member for whom prescriptions for drugs used to treat Hep C are filled
<b>HEP B RXS</b>	Number of prescriptions filled with drugs used to treat Hep B
<b># HEP B UTILIZERS</b>	Number of Medicaid/MCO members for whom prescriptions for drugs used to treat Hep B are filled

<b>HEP B RX COST</b>	Total cost for prescriptions filled with drugs used to treat Hep B
<b>HEP B COST/HEP B UTILIZER</b>	Cost for prescriptions filled with drugs used to treat Hep B per Medicaid/MCO member for whom prescriptions for drugs used to treat Hep B are filled
<b>HIVRXS</b>	Number of prescriptions filled with drugs used to treat HIV
<b>#HIVUTILIZER</b>	Number of Medicaid/MCO members for whom prescriptions for drugs used to treat HIV are filled
<b>HIV RX COST</b>	Total cost for prescriptions filled with drugs with HIV indication
<b>HIVCOST/HIV UTILIZER</b>	Cost for prescriptions filled with drugs with HIV indication per Medicaid/MCO member for whom prescriptions for drugs with HIV indication are filled
<b>TOTAL COST</b>	Total drug cost = Total Drug Reimbursement + Dispensing Fees
<b>TOTAL DRUG REIMBURSEMENT</b>	Total reimbursed for drugs dispensed to Medicaid members
<b>DISPENSINGFEES</b>	Total dispensing fees to pharmacies
<b>TOTAL COST/MEMBER</b>	Total drug cost per Medicaid/MCO member
<b>COST/RXUTILIZER</b>	Total drug cost per Medicaid/MCO member for whom prescriptions for any drug are filled
<b>PDL TOTAL COST</b>	Total drug cost for prescriptions filled for drugs listed on the preferred drug list
<b>PDL COST/MEMBER</b>	Total drug cost for prescriptions filled for drugs listed on the preferred drug list per Medicaid/MCO member
<b>NON PDL TOTAL COST</b>	Total drug cost for prescriptions filled for drugs not listed on the preferred drug list
<b>NONPDL COST/MEMBER</b>	Total drug cost for prescriptions filled for drugs not listed on the preferred drug list per Medicaid/MCO member
<b>PSYCH COST</b>	Total drug cost for prescriptions filled with psychotropic drugs
<b>PSYCH COST/MEMBER</b>	Total drug cost for prescriptions filled with psychotropic drugs per Medicaid/MCO member
<b>PDLPSYCH COST</b>	Total drug cost for prescriptions filled with psychotropic drugs listed on the preferred drug list
<b>PDLPSYCH COST/MEMBER</b>	Total drug cost for prescriptions filled with psychotropic drugs listed on the preferred drug list per Medicaid/MCO member
<b>NONPDL PSYCH COST</b>	Total drug cost for prescriptions filled with psychotropic drugs not listed on the preferred drug list
<b>NONPDL PSYCH COST/MEMBER</b>	Total drug cost for prescriptions filled with psychotropic drugs not listed on the preferred drug list per Medicaid/MCO member
<b>ATYPANTIPSYCHOTIC COST</b>	Total drug cost for prescriptions filled with atypical antipsychotic drugs
<b>ATYPANTIPSYCHOTIC COST/MEMBER</b>	Total drug cost for prescriptions filled with atypical antipsychotic drugs per Medicaid/MCO member
<b>ATYPANTIPSYCHOTIC COST/ATYPANTIPSYCHOTIC UTILIZER</b>	Total drug cost for prescriptions filled with atypical antipsychotic drugs per Medicaid/MCO member for whom prescriptions for atypical antipsychotic drugs are filled
<b>OTC TOTAL COST</b>	Total cost for prescriptions filled for over the counter items

<b>OTCCOST/MEMBER</b>	Total cost for prescriptions filled for over the counter items per Medicaid MCO member
<b>TOTAL INSULIN COST</b>	Total cost for prescriptions filled with insulin
<b>OTC COST LESS INSULIN</b>	Total cost for prescriptions filled for over the counter items minus total cost for prescriptions filled with insulin

<b>H2BLOCKERSTOTAL COST</b>	Total cost for prescriptions filled with any drug listed in the histamine H2 acid reducers drug category
<b>NSAIDSTOTALCOST</b>	Total cost for prescriptions filled with any drug listed in the non-steroidal anti-inflammatory drug category
<b>PPI TOTAL COST</b>	Total cost for prescriptions filled with any drug listed in the proton pump inhibitor drug category
<b># MEMBERS</b>	Number of Medicaid/MCO members
<b>%UTILIZERS</b>	Percentage of Medicaid/MCO members for whom prescriptions are filled
<b># RXS</b>	Number of prescriptions filled for Medicaid/MCO members
<b>AVG # RXS/MEMBER</b>	Average number of prescriptions filled for each Medicaid/MCO member
<b>AVG#RXS/UTILIZER</b>	Average number of prescriptions filled for each Medicaid/MCO member for whom prescriptions are filled
<b># PAs</b>	Number of prior authorizations for drug items requested
<b>% PAs DENIED</b>	Percentage of prior authorization requests denied as compared to total number of prior authorizations requested
<b>#CLAIMS</b>	Number of prescriptions claims
<b>%CLAIMSDENIED</b>	Percentage of prescription claims denied as compared to total number of paid claims
<b>#PRESCRIBERS</b>	Number of Medicaid/MCO providers who prescribed medications for Medicaid/MCO members for whom prescriptions were filled
<b># RXS/PRESCRIBER</b>	Number of prescriptions filled for Medicaid/MCO members filled for any drug per provider who prescribed medications for Medicaid/MCO members for whom prescriptions were filled
<b>#CONTROLS/ PRESCRIBER</b>	Number of prescriptions filled for controlled (scheduled) narcotics per provider who prescribed medications for Medicaid/MCO members for whom prescriptions were filled
<b>#PHARMACIES</b>	Number of pharmacies where prescriptions were filled for Medicaid/MCO members
<b>AVG COST/RX</b>	Average cost of prescriptions filled for Medicaid/MCO members per prescription filled for Medicaid/MCO members
<b>SUBOXONERXS</b>	Number of Suboxone prescriptions filled for Medicaid/MCO members
<b>ADHD RXS</b>	Number of prescriptions filled with any drug listed in the attention deficit hyperactivity disorder drug category
<b># LOCK IN MEMBERS</b>	Number of Medicaid/MCO members placed in a Lock In program

Column Label	Description
Nov 11	Information for the entire month
Dec 11	Information for the entire month
Jan 12	Information for the entire month
% Change per Month	The percentage change realized from one rolling month to the next
% Change per Year	The percentage change realized from one rolling year to the next
Average per Month	The average of the requested information per month
Y-T-D	Total of requested information through the last reporting period

Report #	50A,50B	Created:	01/01/2017
Name:	PostPaymentBillingRecovery	Last Revised:	

Group:	ThirdPartyLiability	ReportStatus:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Reports all recoveries for monies collected from commercial insurance carriers during the reporting period from claims that were paid prior to the commercial insurance carrier being identified

Report 50A reports all non-pharmacy recoveries; Report 50B reports all pharmacy recoveries.

**Sample Layout:**

Member Medicaid ID	Member Name	Claim ICN	Insurance Carrier Name	MCO Paid Amount	Amount Recovered

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Column Label	Description
Member Medicaid ID	The Member's Medicaid ID
Member Name	Concatenate the Member's 'Last Name', 'First Name' 'Middle Initial'.
Claim ICN	The MCO claim internal control number for the claim being reported.
Name of Insurance Carrier	The name of the company that issued the insurance policy
MCO Paid Amount	The net amount the claim adjudicated to a paid status.
Amount Recovered	The total amount recovered from the commercial insurance carrier by the MCO.

Report#:	51	Created:	01/09/2012
Name:	Operational Changes	Last Revised:	
Group:	Other Activities	ReportStatus:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	KentuckyDepartmentforMedicaidServices		

**Description:**

Identify any operational changes or relevant to the operations of the MCO not otherwise covered during the report period.

**Sample Layout:**

Kentucky Department for Medicaid Services

MCO Report # 51: Operational Changes

MCOName:	<b>DMS Use Only</b>
Report Date:	Received Date:
Report Period From:	Reviewed Date:
Report Period To:	Reviewer:

- 
- I.

Operational Change
- II.

Operational Change
- III.

Operational Change

Report#:	52	Created:	02/14/2012
Name:	Expenditures Related to MCO's Operations	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

MCO should provide the Executive Management's salary, bonus, other compensation, travel and other expenses based upon the reporting period.

**Sample Layout:**

							Reporting Period	
Category	Positions	Salary	Bonus	Other Compensation	Travel	Other Expenses	Begin Date	End Date
Executive Management	Executive Officer/CEO							
Executive Management	Medical Director							
Executive Management	Pharmacy Director							
Executive Management	Dental Director							
Executive Management	CFO							
Executive Management	Compliance Director							
Executive Management	Quality Improvement Director							
Executive Management	Sub-Total							
Executive	All other Executives							

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Executive Management	Capable and responsible for the oversight of the entire operation.
Executive Director/CEO	Primary contact and will be authorized to represent the Contractor regarding inquiries pertaining to the contract, will be available during normal business hours, and will have decision-making authority in regard to urgent situations that arise.
Medical Director	Actively involved in all major clinical programs and Quality Improvement components.
Pharmacy Director	Coordinate, manage and oversee the provision of pharmacy services to Members.
Dental Director	Actively involved in all major dental programs.
CFO	Ensure compliance with adopted standards and review expenditures for reasonableness and necessity.
Compliance Director	Maintain current knowledge of Federal and State legislation, Legislative initiatives, and regulations relating to Contractor and oversee the Contractor's compliance with the laws and Contract requirements of the Department. Serve as the primary contact for and facilitate communications between Contractor leadership and the Department relating to Contract compliance issues.
Quality Improvement Director	Responsible for the operation of the Contractor's QAPI Program and any QAPI Program of its subcontractors.

Sub-Total	Provide the subtotal of each of the Executive Management team above
All Other Executives	Provide a total of all other Executive Management as defined in the MCO contract.

Column Label	Description
Salary	Provide the salary of only the Kentucky's line of business. MCO may disclose an estimated allocation based on the time allocated to Kentucky. Information related to the Contractor's ultimate parent company's Executive Management need not be disclosed.
Bonus	Unless guaranteed, or actually paid during the report period, bonuses disclosed may be target amounts for the period disclosed expressed as a percentage of base salary.
Other Compensation	Is limited to other cash compensation actually paid during the reporting period, and may exclude amounts realized or realizable during the period through grant, vesting or exercise of stock options, restricted stock, stock appreciation rights, phantom stock plans, or other long term non-cash incentives.
Travel	Provide the travel of only the Kentucky's line of business. MCO may disclose an estimated allocation based on the time allocated to Kentucky. Information related to the Contractor's ultimate parent company's Executive Management need not be disclosed.
Other Expenses	Provide the other expenses of only the Kentucky's line of business. MCO may disclose an estimated allocation based on the time allocated to Kentucky. Information related to the Contractor's ultimate parent company's Executive Management need not be disclosed.
Begin Date	Provide the begin date of the report period.
End Date	Provide the end date of the report period.

Report #:	53	Created:	09/12/2011
Name:	Prompt Payment	Last Revised:	09/24/2011
Group:	Financial and Information Systems	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	In accordance with DOI requirements.		
Due Date:	Date Submitted to DOI		
Submit To:	Kentucky Department of Insurance Kentucky Department for Medicaid Services		

#### Description:

MCOs are required to comply with the Kentucky Department of Insurance (DOI) requirements for prompt payment reporting as referenced in the DOI HIPMC-CP-3 Prompt Payment Reporting Manual. The DOI requires a quarterly submission of the prompt payment report. A copy of the quarterly prompt payment report is required to be submitted to the Department for Medicaid Services (DMS) at the same time the report is submitted to the DOI. Any revisions of the documents submitted to the DOI are also to be submitted to the DMS at the same time.

Report #:	54	Created:	08/28/2011
Name:	COB Savings	Last Revised:	02/27/2015
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

#### Description:

Reports all Coordination of Benefit (COB) savings due to other insurance payment, including Medicare, for which the claim submission includes and the MCO processed/paid the claim accordingly. The report is to include claims when the other insurance paid zero dollars because the service was not covered by the other insurance.

Sample Layout:

COB/TBL Savings

Member Medicaid ID	Member Name	Claim ICN	MCO Paid Amount	COB Amount
Total				

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Total	Provide a total of all reported activity for MCO Paid Amount, COB Amount, Other Insurance Deductible Amount and Other Insurance Co-Pay Amount.

Column Label	Description
Member Medicaid ID	The Member's Medicaid ID
Member Name	Concatenate the Member's 'Last Name', 'First Name' 'Middle Initial'.
Claim ICN	The MCO claim internal control number for the claim being reported.
MCO Paid Amount	The net amount the claim adjudicated to a paid status. Note: When there is a Provider outstanding balance due and the claim payment was reduced by the outstanding balance do not report the payment Financial paid out.
COB Amount	The amount the other insurance paid on the claim.



Report #:	55	Created:	08/28/2011
Name:	Medicare Cost Avoidance	Last Revised:	02/27/2015
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

Reports the Medicare crossover claims that were denied during the reporting period because the claim was submitted without first having been submitted to Medicare for payment.

Sample Layout:

Medicare Cost Avoidance			
Medicaid Member ID	Member Name	Claim ICN	Amount Denied Due To Medicare
Monthly Total			

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Total	Provide a total of all reported activity for Denied Amount, Medicare Payment, Medicare Deductible and Medicare Coinsurance.

Column Label	Description
--------------	-------------

Member Medicaid ID	The Member's Medicaid ID
Member Name	Concatenate the Member's 'Last Name', 'First Name' 'Middle Initial'.
Claim ICN	The MCO claim internal control number for the claim being reported.
Denied Amount Due to Medicare	The billed amount the MCO denied due to Medicare coverage.

Report #:	56	Created:	08/28/2011
Name:	Non-Medicare Cost Avoidance	Last Revised:	02/27/2015
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The report lists the claims that were denied during the reporting period because the claim was submitted without first having been submitted to another Insurer for payment. The report is not to include Medicare crossover claims.

**Sample Layout:**

Non-Medicare TPL Cost Avoidance			
Medicaid Member ID	Member Name	Claim ICN	Amount Denied Due To Non-Medicare TPL
Monthly Total			

**Reporting Criteria:**

General Specifications	Definition
DateFormat	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Total	Provide a total of all reported activity for Denied Amount, Other Insurance non-Medicare Payment, Other Insurance non-Medicare Deductible and Other Insurance non-Medicare Coinsurance.

Column Label	Description
Member Medicaid ID	The Member's Medicaid ID
Member Name	Concatenate the Member's 'Last Name', 'First Name' 'Middle Initial'.
Claim ICN	The MCO claim internal control number for the claim being reported.
Denied Amount	The billed amount the MCO denied due to non-Medicare TPL.

Report #:	57	Created:	08/27/2011
Name:	Potential Subrogation	Last Revised:	02/27/2015
Group:	Third Party Liability	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Provides report for cases where the MCO's Member has had an accident and there is potential for a liable third party or subrogation claim.

**Sample Layout:**

Active/Potential Subrogation/Liable Party							
Member Medicaid ID	Member Name	Date of Injury	Attorney/Liable Party Information	Lien/Claim Amount	Recovered Amount	Status/Closed Date	Comments

**Reporting Criteria:**

General Specifications	Definition
DateFormat	All report dates are to be in the following format: mm/dd/yyyy
SortOrder	The report is to be sorted in ascending order by 'Member Name'.

Row Label	Description
NA	NA

Column Label	Description
Member Medicaid ID	The Member's Medicaid ID reported as a text string.
Member Name	Concatenate the Medicaid Member's 'Last Name', 'First Name', 'Middle Initial'
Date of Injury	The date of the actual injury/accident.
Attorney/Liable Party Information	The attorney/liable party name, address and contact information.
Lien Claim Amount	The MCO lien or claim amount.
Recovered Amount	The MCO recovered amount from the attorney/liable party.
Status/Closed Date	Awaiting additional funds or Date case closed if applicable
Comments	Regarding pending payment or any special circumstance

Report #:	58	Created:	08/20/2011
Name:	Original Claims Processed	Last Revised:	08/29/2011
Group:	Claims Processing	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Provides the number of original clean claims processed during a reporting period reported by Billing Provider Type and claim status. There are four claim statuses to be included in the report:

Received;  
Pay;  
Deny; and  
Suspended

Two (2) Billing Provider Types are further broken down as follows:

Billing Provider Type 01 General Hospital  
Inpatient;  
Outpatient;  
Emergency Room; and  
Inpatient/Outpatient Other

Billing Provider Type 54 Pharmacy  
Pharmacy non-Behavioral Health Brand;  
Pharmacy non-Behavioral Health Generic;  
Pharmacy Behavioral Health Brand; and  
Pharmacy Behavioral Health Generic

Sample Layout:

	Claims Received			
	Total Count	Total Processed	Total Charges	Avg. Charges
Total All Claims				
Inpatient				
Outpatient				
Emergency Room				

Inpatient/Outpatient Other				
Mental Hospital				
PRTF				
Specialized Child Svc Clinics				

	Adjudicated to Pay Status					
	Total Count	Percent	Total Charges	Avg. Charges	Total Paid	Avg. Paid
Total All Claims						
Inpatient						
Outpatient						
Emergency Room						
Inpatient/Outpatient Other						
Mental Hospital						
PRTF						
Specialized Child Svc Clinics						

	Adjudicated to Deny Status			
	Total Count	Percent	Total Charges	Avg. Charges
Total All Claims				
Inpatient				
Outpatient				
Emergency Room				
Inpatient/Outpatient Other				
Mental Hospital				
PRTF				
Specialized Child Svc Clinics				

	Placed in Suspended Status			
	Total Count	Percent	Total Charges	Avg. Charges
Total All Claims				
Inpatient				
Outpatient				
Emergency Room				
Inpatient/Outpatient Other				

PRTF				
Specialized Child Svc Clinics				

**Reporting Criteria:**

General Specifications	Definition
Claim	Claim is defined as an original clean claim.
Claim Count	A claim count of one is applied to each claim. Therefore a claim that pays on the header and a claim that pays on the detail will both have a count of one.
Billing Provider Type	Billing Provider Type is designated with a state specific two (2) character field. Example: Billing Provider Type 01 – General Hospital
Provider Type Category	Billing Provider Type Category is a breakdown of a Billing Provider Type by specified criteria.
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
Total All Claims	Includes all Provider Types and Provider Type Categories included in the report.
'Provider Type'	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk.
'Provider Type Category'	Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Other non-Medicaid Provider Type	Category is used to report claims processed for Providers that do not have a Medicaid Provider ID or for Providers with a Provider Type that Medicaid does not recognize.

Claim Status	Column Label	Description
Received	Total Count	Total Count of all Original Claims received during the reporting period.
Received	Total Processed	Total Count of all Original Claims processed during the reporting period to a status of Pay, Deny or Suspended.
Received	Total Charges	Total charges for all received original claims. A claim that pays at the header should use the charges from the header. A claim that pays at the detail should include the charges from all the details.
Received	Avg. Charges	Calculated Field: 'Total Charges' from received status divided 'Total Count' from received status.
Pay	Total Count	Total Count of all Original Claims that adjudicated to a Pay status.
Pay	Percent	Calculated Field: 'Total Count' from pay status divided by 'Total Processed' from received status.
Pay	Total Charges	Total charges from original claims adjudicated to a pay status. Header paid claims will use the charges from the Header. Detail paid claims will use charge from the line items that have a pay status. Denied line item charges are not to be included in Total Charges.
Pay	Avg. Charges	Calculated Field: 'Total Charges' from pay status divided by 'Total Count' from pay status.
Pay	Total Paid	The total adjudicated claim paid amount by the MCO. Example: A claim adjudicated to pay \$100. There is an outstanding A/R in financial for \$200. The MCO should report the \$100 adjudicated paid amount and not the \$0 financial payment.

Pay	Avg. Paid	Calculated Field: 'Total Paid' from pay status divided by 'Total Count' from pay status.
Deny	Total Count	Total Count of all Original that adjudicated to a Deny status.
Deny	Percent	Calculated Field: 'Total Count' from deny status divided by 'Total Count' from received status.
Deny	Total Charges	Total charges for all denied original claims. A claim that pays at the header should use the charges from the header. A claim that pays at the detail should include the charges from all the details.
Deny	Avg. Charges	Calculated Field: 'Total Charges' from deny status divided by 'Total Count' from deny status.
Suspended	Total Count	Total Count of all Original Claims that moved to a suspended status. The claim shall be counted even if the claim later was changed to a Pay or Deny status during the reporting period.

Suspended	Percent	Calculated Field: 'Total Count' from suspended status divided by 'Total Count' from received status.
Suspended	Total Charges	Total charges for all suspended original claims. A claim that pays at the header should use the charges from the header. A claim that pays at the detail should include the charges from all the details.
Suspended	Avg. Charges	Calculated Field: 'Total Charges' from suspended status divided by 'Total Count' from suspended status.



Report#:	59	Created:	09/10/2011
Name:	Prior Authorizations	Last Revised:	7/1/2015
Group:	Medical Management	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The report list the Prior Authorization (PA) activity during the reporting period. All PAs required by the MCO are to be listed regardless of the level of activity during the reporting period. If an MCO adds or deletes a PA from their program requirements then the MCO is to report that information when submitting the report.

**Sample Layout:**

Provider Type/Category	Prior Authorizations Requested	Prior Authorization (PA)						Prior Authorizations Denied
		Prior Authorizations Approved			Prior Authorizations Partial Approved			
		Medical	Medical	Medical	Medical	Medical	Medical	

		Necessity (no MCO Service Limits)	Necessity and within MCO Service Limits	Necessity and Exceeded MCO Service Limits	Necessity (no MCO Service Limits)	Necessity and within MCO Service Limits	Necessity and Exceeded MCO Service Limits	
--	--	-----------------------------------	---	---	-----------------------------------	---	---	--

Inpatient								
Outpatient								
Emergency Room								
Inpatient/Outpatient								
Other								
Mental Hospital								
Other non-Medicaid								
Provider Type								

Total	0	0	0	0	0	0	0	0
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**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
'Provider Type'	Crosswalk of Provider Type and Provider Specialty to each Provider Description listed is provided in Exhibit A: Provider Type and Specialty Crosswalk.
'Provider Type Category'	Crosswalk of Provider Type Categories for General Hospital and Pharmacy are provided in Exhibit B: Billing Provider Type Category Crosswalk
Other non-Medicaid Provider Type	Category is used to report prior authorizations processed for Providers that do not have a Medicaid Provider ID or for Providers with a Provider Type that Medicaid does not recognize.
Total	Report the total of all PA activity listed in the report.

Column Label	Description
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Prior Authorizations Requested	The total number of prior authorizations that were requested for each specific 'Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
Prior Authorizations Approved	The total number of prior authorizations that were approved for each specific 'Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
PAs Approved: Medical Necessity (no MCO service Limits)	Prior authorizations required for medical necessity determination only. There are no MCO service limits for the service being prior authorized and the MCO approved all of the units requested.
PAs Approved: Medical Necessity and within MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved all of the units requested and the units approved did not exceed MCO service limits.

PAs Approved: Medical Necessity and Exceeded MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved all of the units requested and the total units approved
Prior Authorizations Partially Approved	The total number of prior authorizations that were partially approved for each specific 'Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.
PAs Partially Approved: Medical Necessity (no MCO service Limits)	Prior authorizations required for medical necessity determination only. There are no MCO service limits for the service being prior authorized and the MCO approved some but not all of the units requested.
PAs Partially Approved: Medical Necessity and within MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved some but not all of the units requested and the units approved did not exceed MCO service limits.
PAs Partially Approved: Medical Necessity and Exceeded MCO Service Limits	The MCO has service limits and a medical necessity determination for the service that is being prior authorized. Only report the prior authorizations if the MCO approved some but not all of the units requested and the total units approved exceeded the MCO service limits.
Prior Authorizations Denied	The total number of prior authorizations that were denied for each specific 'Provider Type/Category'. If no PA activity was requested for a specific 'Provider Type/Category' report 0.



Report #:	60	Created:	08/20/2011
Name:	Original Claims Payment Activity	Last Revised:	02/27/2015
Group:	Claims Processing	Report Status:	Active
Frequency:	Monthly	Exhibits:	A, B
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Provides the number of original clean claims paid during a reporting period and length of time from receipt of a clean original claim to claim payment; the number of original clean claims denied during a reporting period and length of time from receipt of a clean original claim to claim denial; the number of original clean claims in a suspended status during a reporting period and length of time from receipt of an original claim.

**Sample Layout:**

	Claim Activity				Total Claims
	1-30 Days	31-60 Days	61-90 Days	91+ Days	
Total All Claims Paid					
Total All Claims Denied					
Total All Claims Suspended					

**Reporting Criteria:**

General Specifications	Definition
Claim	Claim is defined as an original clean claim that has been paid/denied/suspended.
ClaimCount	A claim count of one is applied to each paid/denied/suspended claim. Therefore a header paid claim that is paid/denied/suspended and a detailed paid claim that is paid/denied/suspended on all details will both have a count of one.
DateFormat	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
Total All Claims Paid	Includes all clean claims that have been paid in the reporting period
Total All Claims Denied	Includes all clean claims that have been denied in the reporting period
Total All Claims Suspended	Includes all clean claims that have been suspended in the reporting period

Column Label	Description
1-30Days	Total count of all claims paid/denied/suspended during the reporting period for which the claim was in process for 1 to 30 calendar days from receipt of a clean claim.
31-60 Days	Total count of all claims paid/denied/suspended during the reporting period for which the claim was in process for 31 to 60 calendar days from receipt of a clean claim.
61-90 Days	Total count of all claims paid/denied/suspended during the reporting period for which the claim was in process for 61 to 90 calendar days from receipt of a clean claim.
91+ Days	Total count of all claims paid/denied/suspended during the reporting period for which the claim was in process for 91 or more calendar days from receipt of a clean claim.
Total Claims	Total count of all claims paid/denied/suspended during the reporting period.

Report#:	64	Created:	10/01/2016
Name:	Monthly Benefit Payments	Last Revised:	
Group:	Financial	Report Status:	Active
Frequency:	Monthly	Exhibits:	D, E, F
Period:	First day of month through the last day of the month.		
Due Date:	15 <sup>th</sup> of the month following the reporting period.		
Submit To:	KentuckyDepartmentforMedicaidServices		

#### Description:

The Monthly Benefit Payments report provides MCO financial activity for the Medicaid expansion population, Kentucky Children's Health Insurance Program (KCHIP), and all other Medicaid populations by Month and State Category of Service. Report only includes financial activity related to Benefits including claims, claim adjustments, mass adjustments, sub-capitation, and other financial payments/recoupment activity not processed as part of claims activity. Categories of Service are grouped by Medicaid Mandatory and Medicaid Optional Services. Criteria to properly identify and report EPSDT services and KCHIP services are to be applied as outlined below.

#### Sample Layout:

COS	COS Description	Expansion Medicaid	KCHIP	Other Medicaid	Total
Medicaid Mandatory Services					
02	Inpatient Hospital				
12	Outpatient Hospital				
	Subtotal: Mandatory Services				
03	Mental Hospital				
04	Renal Dialysis				
	Subtotal: Optional Services				
	Total: Mandatory and Optional Services				
	Reinsurance				
	Pharmacy Rebates				
	Grand Total				

#### Reporting Criteria:

General Specifications	Definition
Financial Activity	Payments reported are to be based on date of payment.
EPSDT Services	Multiple Provider Types may provide EPSDT services. Reference Exhibit E for EPSDT Category of Service crosswalk for additional information regarding the identification of EPSDT services.
DateFormat	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Subtotal: Mandatory Services	Calculated Field: Total for all mandatory category of services listed in the report.
Subtotal: Optional Services	Calculated Field: Total for all optional category of services listed in the report.
Total: Mandatory and Optional Services	Calculated Field: Total of 'Subtotal: Mandatory Services' and 'Subtotal: Optional Services'.
Reinsurance	MCO premium payments for stop-loss insurance coverage.
Pharmacy Rebates	Drug Rebates collected by the MCO. 'Pharmacy Rebates' is to be reported as a negative value. Note: The state is responsible for collecting federal drug rebates.
Grand Total	Calculated Field: Total of 'Total: Mandatory and Optional Services', 'Reinsurance' and 'Pharmacy Rebates'.

Column Label	Description
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COS	Category of Service: A two digit, State specific identification of services primarily identified by use of Provider Type. Reference Exhibit D for Category of Service crosswalk.
COS Description	Description for 'COS'
Expansion Medicaid	The Expansion Medicaid population services are to be reported separately from the KCHIP population services. Population to be those members who qualified based on criteria set forth in the Affordable Care Act (ACA).  Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
KCHIP	The Kentucky Children's Health Insurance Program (KCHIP) population services are to be reported separately from the Medicaid population services. Populations to be included are based on the Medicaid Eligibility Groups (MEGs):
	1. MCHIP 2. SCHIP  Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
Other Medicaid	All Medicaid members not reported in the previous two groups.

Report#:	65	Created:	02/13/2012
Name:	Foster Care	Last Revised:	07/25/2015
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services Kentucky Department for Community Based Services		

**Description:** Quarterly report provides information on the Foster Care population for each MCO and broken down by Region.

**Sample Layout:**

MCO Region	Foster Care Region	Number of New Foster Care Members	Number of Existing Foster Care Members	Number of New Foster Care Members Enrolled into CM	Number of Existing Foster Care Members Enrolled into CM	Number of New Foster Care Members Enrolled into DM	Number of Existing Foster Care Members Enrolled into DM	Number of New Foster Care Members with Completed HRAs	Number of Existing Foster Care Members with Completed HRAs

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region

Row Label	Description
NA	NA

Column Label	Description
MCO Region	Provide the member's MCO region.
Foster Care Region	Provide the member's Foster Care region.
Number of New Foster Care Members	Provide the total number of new Foster Care Members during the month.
Number of Existing Foster Care Members	Provide the total number of existing Foster Care Members during the month.
Number of New Foster Care Members Enrolled into Case Management	Provide the total number of new Foster Care Members enrolled into Case Management during the month.
Number of Existing Foster Care Members Enrolled into Case Management	Provide the total number of existing Foster Care Members enrolled into Case Management during the month.

Number of New Foster Care Member Enrolled into Disease Management	Provide the total number of new Foster Care Members enrolled into Disease Management during the month.
Provide the total number of Existing Foster Care Members enrolled into Disease Management	Provide the total number of existing Foster Care Members enrolled into Disease Management during the month.
Number of New Foster Care Members with Completed HRAs	Provide the total number of new Foster Care Members with completed HRAs during the month.
Number of Existing Foster Care Members with Completed HRAs	Provide the total number of existing Foster Care Members enrolled into HRAs during the month.



Report#:	66	Created:	02/10/2012
Name:	Guardianship	Last Revised:	07/15/2015
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		
	Kentucky Department for Aging and Independent Living		

**Description:** Quarterly report provides information on the Guardianship population for each MCO and broken down by Region.

**Sample Layout:**

MCO Region	Guardian ship Region	Number of New Guardian ship Members	Number of Existing Guardian ship Members	Number of New Guardian ship Members Enrolled into CM	Number of Existing Guardian ship Members Enrolled into CM	Number of New Guardian ship Members Enrolled into DM	Number of Existing Guardian ship Members Enrolled into DM	Number of New Guardian ship Members with Completed HRAs	Number of Existing Guardian ship Members with Completed HRAs
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**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in order: MCO Region

Row Label	Description
NA	

Column Label	Description
MCO Region	Provide the member's MCO region.
Guardianship Region	Provide the member's Guardianship region.
Number of Guardianship Members	Provide the total number of new Guardianship Members during the month.
Number of Existing Guardianship Members	Provide the total number of existing Guardianship Members during the month.
Number of New Guardianship Members Enrolled into Case Management	Provide the total number of new Guardianship Members enrolled into Case Management during the month.
Number of Existing Guardianship Members Enrolled into Case Management	Provide the total number of existing Guardianship Members enrolled into Case Management during the month.
Number of New Guardianship Member Enrolled into Disease Management	Provide the total number of new Guardianship Members enrolled into Disease Management during the month.
Provide the total number of Existing Guardianship Members enrolled into Disease Management	Provide the total number of existing Guardianship Members enrolled into Disease Management during the month.
Number of New Guardianship Members with Completed HRAs	Provide the total number of new Guardianship Members with completed HRAs during the month.
Number of Existing Guardianship Members with Completed HRAs	Provide the total number of existing Guardianship Members enrolled into HRAs during the month.

Report#:	68	Created:	08/21/2011
Name:	Additions to Provider Network	Last Revised:	10/01/2011
Group:	Provider Enrollment	Report Status:	Active
Frequency:	Monthly	Exhibits:	C
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Report documents additions to the MCO Provider Network

**Sample Layout:**

NPI	Medicaid ID	Last/Entity Name	First Name	Phone	Address 1	Address 2	City	State	Zip	County Name	Specialty

**Reporting Criteria:**

Terminology	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Column Label	Description
NPI	The Provider's NPI
Medicaid ID	The Provider's Medicaid Identification Number
Last/Entity Name	For an individual Medical Provider report the last name of the Provider; When the addition applies to a Provider group report the group name; When the addition applies to a subcontractor report the last name of the company contact.
First Name	The Provider's first name
Phone	Provide the contact number for the 'Last/Entity Name' listed.
Address 1	First line of the mailing address for the 'Last/Entity Name' listed.
Address 2	Second line of the mailing address for the 'Last/Entity Name' listed.
City	City of the mailing address for the 'Last/Entity Name' listed.
State	A two character designation for the state of the mailing address for the 'Last/Entity Name' listed.
Zip	Five character zip code of the mailing address for the 'Last/Entity Name' listed.
County Name	The complete name of the county where the provider is located. (County name is not necessary if the provider is located out of Kentucky)
Specialty	The medical specialty of the 'Last/Entity Name' listed. (Do not use abbreviations)

Report#:	69	Created:	08/21/2011
Name:	Termination from MCO Activity	Last Revised:	02/16/2015
Group:	Provider Enrollment	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:** Report documents terminations to the MCO Provider Network

NPI	Medicaid ID	Last/Entity Name	First Name	Phone	Address 1	Address 2	City	State	Zip	County Name	Specialty	Reason
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General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Reason	<p>The reason for suspension or termination given by the MCO. Combines the Reason Code and Reason Code Description. Format:</p> <p>'Reason Code'&lt;space&gt;'-'&lt;space&gt;'Reason Code Description'</p> <p>List of values for suspension or termination are provided in Exhibit C: Provider Enrollment Activity Reasons.</p>
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Report #:	70	Created:	08/21/2011
Name:	Denial of MCO Participation	Last Revised:	09/24/2011
Group:	Provider Enrollment	Report Status:	Active
Frequency:	Monthly	Exhibits:	C
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Report documents any Provider of Subcontractor who is denied participation with the MCO. Only those Providers or Subcontractors who are not currently participating with the MCO are to be reported.

[illegible]

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy

Row Label	Description
NA	NA

Column Label	Description
NPI	NPI should be reported as a text string.  When the denial applies to a Medical Provider report the Provider's NPI.  When the denial is for a subcontractor report 'Subcon'.
Last/Entity Name	When the denial applies to an individual Medical Provider report the last name of the Provider. When the denial applies to a Provider group report the group name.

	When the denial applies to a subcontractor report the last name of the company contact.
First Name	When the denial applies to an individual Medical Provider report the first name of the Provider. When the denial applies to a Provider group report the group name. When the denial applies to a subcontractor report the first name of the company contact.
Title	When the denial applies to an individual Medical Provider report the title of the Provider. When the denial applies to a Provider Group report 'NA'. When the denial applies to a subcontractor report the title of the company contact.
Phone	Provide the contact number for the 'Last/Entity Name' listed.
Addr. 1	First line of the mailing address for the 'Last/Entity Name' listed.
Addr. 2	Second line of the mailing address for the 'Last/Entity Name' listed.
City	City of the mailing address for the 'Last/Entity Name' listed.
State	A two character designation for the state of the mailing address for the 'Last/Entity Name' listed.
Zip	Five character zip code of the mailing address for the 'Last/Entity Name' listed.
County	A three character code for the county of the mailing address for the 'Last/Entity Name' listed.
Co. Name	The name of the county of the mailing address for the 'Last/Entity Name' listed.
Reason	The reason for denial given by the MCO. Combines the Reason Code and Reason Code Description. Format:  'Reason Code'<space>'<space>'Reason Code Description'  List of values for denial are provided in Exhibit C: Provider Enrollment Activity Reasons.

Report #:	71	Created:	09/01/2011
Name:	Provider Outstanding Account Receivables	Last Revised:	09/26/2011
Group:	Finance and Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The Provider Outstanding Account Receivables report contains all accounts receivable that have reached 180 days or older in age. If there are no accounts receivable 180 days or older as of the last day of the reporting period then the report is to be submitted with the 'Total' values set to \$0.00 and the following comment located at the bottom of the report:

'NO ACCOUNTS RECEIVABLE 180 DAYS OR OLDER TO REPORT AS OF THE END OF THE REPORTING PERIOD'

Sample Layout:

Outstanding Account Receivables 180 Days or Older

AR ID	Provider Tax ID/SSN	Medicaid Provider ID	Provider NPI	Provider Name	AR Setup Date	AR Age	AR Setup Reason	AR Setup Amount	Revised AR Setup Amount	Disposition	AR Balance	Write Off Indicator	TPL Indicator
Total								\$0.00	\$0.00	\$0.00	\$0.00		

NO ACCOUNTS RECEIVABLE 180 DAYS OR OLDER TO REPORT AS OF THE END OF THE REPORTING PERIOD

Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by provider name.

Row Label	Description
Total	Calculated Field: Total of all reported in each column for 'AR Setup Amount', 'Revised AR Setup Amount', 'Disposition' and 'AR Balance'.

Column Label	Description
AR ID	The MCO identifier for the account receivable.
Provider Tax ID/SSN	Billing Provider Federal Tax ID (FEIN) or SSN of the Billing Provider.
Medicaid Provider ID	The Provider's Medicaid ID
Provider NPI	The Provider's NPI number as reported on the claim.
Provider Name	Concatenate the Provider's 'Last Name', 'First Name' 'Middle Initial'.
AR Setup Date	The date the account receivable was established.
AR Age	The age measured in days of the account receivable as of the last day of the reporting period. The setup date for the account receivable is to be counted.
AR Setup Reason	The reason behind the creation of the account receivable.
AR Setup Amount	The amount originally requested from the provider.
Revised AR Setup Amount	When MCO procedures allow modification of the original account receivable setup amount due to a dispute resolution or write off report the new account receivable setup amount. If the account receivable balance is adjusted rather than the setup amount report the original account receivable setup amount.
Disposition	The total amount applied to the account receivable during the reporting period. Dispositions may include payments received, recoupment or adjustments (dispute resolution or write offs).
AR Balance	The balance of the account receivable as of the last day of the reporting period.
Write Off Indicator	Indicates if the account receivable was partially or completely written off. Valid values are:  N = Account receivable not written off. C = Account receivable completely written off. P = Account receivable partially written off.
TPL Indicator	Indicates if the account receivable resulted from identification of TPL. Valid values are 'Y' or 'N'.

Report #:	72	Created:	09/07/2011
Name:	Member Violation Letters and Collections	Last Revised:	09/25/2011
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

Description:

The report lists the complaints received and actions taken regarding potential Medicaid program violations by a Member. The MCO is to open a case for each complaint received and document the related activity for all active/open cases during the reporting period.

A copy of each Medicaid Program Violation (MPV) letter with signature that is mailed during the reporting period is to be provided as an attachment when the Member Violation Letters and Collections report is submitted.

**Sample Layout:**

Medicaid Program Violation Letters and Collections												
Case	Case	Member	Member	Member	Date Complaint	Source of	Summary of	Date Case	Actions	Overpayment Amount	Overpayment Collected	Total Overpayment Collected

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted as follows: First sort order by 'Case Status' (N, A, C, I). Second sort order by ascending 'Date Case Opened'.

Row Label	Description
NA	NA

Column Label	Description
Case Status	Identifies if the case is New, Existing or Closed. Valid values are:  N = New Case opened during reporting period. A = Active Case and status update C = Closed case with disposition I = Inactive case and status description  Only one Case Status is to be reported per line. If a Case is Opened and Closed during the same reporting period then one record with Case Status = N and one record with a Case Status = C will be reported for the case.
Case ID	The Case unique identifier assigned by the MCO.
Member Name	The name of the member the complaint is against. Concatenate the Member's <Last Name>, <First Name> <Middle Initial>.

Member Medicaid ID	The Member's Medicaid ID.
Member MCO ID	The Member's MCO ID.
Date Complaint Received	The date the complaint was received by the MCO.
Source of Complaint	Where the complaint was received from (e.g. hotline).
Summary of Complaint	Short description of the complaint.
Date Case Opened	Date case was opened for review by the MCO. A case shall be opened for all complaints received.
Actions Taken	Activity that occurred after case opened. Valid values are:  <ol style="list-style-type: none"> <li>1. IO = Investigation Opened</li> <li>2. ICNA = Investigation closed with no further action with disposition description</li> <li>3. MPV = Medicaid Program Violation Letter Sent</li> <li>4. MPV-NR = Member has not responded to MPV Letter</li> <li>5. MPV-PS = Member has responded and set up payment schedule/plan</li> <li>6. MPV-F = Member has paid in full</li> </ol> More than one value may be reported per record.
Overpayment Amount	Amount of overpayment identified during the investigation.
Overpayment Collected	Amount of overpayment collected during the reporting period.
Total Overpayment Collected	The total amount of the overpayment collected through the end of the reporting period. Includes previous reporting period collections.

Report#:	73	Created:	09/07/2011
Name:	Explanation of Member Benefits, (EOMB)	Last Revised:	10/17/2011
Group:	Program Integrity	ReportStatus:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	KentuckyDepartmentforMedicaidServices		

**Description:**

The report identifies the MCO activity in verifying Member benefits for which the MCO received, processed and paid a claim in accordance with 42 CFR 455.20. A minimum of 500 claims is to be sampled for purpose of complying with 42 CFR 455.20. An EOMB is to be mailed within 45 days of payment of claims.

**Sample Layout:**

Meets 42 CFR 455.20	Member Region	Billing Provider Type	MCO ICN	Date of Contact	Member Name	Member Medicaid ID	Date of Service	Service Code	Service Code Description
Total (Y)									
Total									

(N)									
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Meets 42 CFR 455.20	Member Region	Billing Provider Type	MCO ICN	Payer	Billing Provider Name	Billing Provider Medicaid Number	Rendering Provider Name	Rendering Provider Medicaid Number	Billed Amount	Paid Amount	Response	Action
Total (Y)												
Total (N)												

**Reporting Criteria:**

General Specifications	Definition
DateFormat	All report dates are to be in the following format: mm/dd/yyyy
SortOrder	The report is to be sorted in ascending order by number in column A.

Row Label	Description
Total (Y)	<p>Total (Y) for MCO ICN: Report the unduplicated count of 'MCO ICN' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'.</p> <p>Total (Y) for Billed Amount: Report the sum of all 'Billed Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'.</p> <p>Total (Y) for Paid Amount: Report the sum of all 'Paid Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'.</p> <p>Total (Y) for Collections: Report the sum of all 'Collections' for which the 'Meets 42 CFR 455.20' indicator was set to 'Y'.</p>

Total (N)	<p>Total (N) for MCO ICN: Report the unduplicated count of 'MCO ICN' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'.</p> <p>Total (N) for Billed Amount: Report the sum of all 'Billed Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'.</p> <p>Total (N) for Paid Amount: Report the sum of all 'Paid Amount' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'.</p> <p>Total (N) for Collections: Report the sum of all 'Collections' for which the 'Meets 42 CFR 455.20' indicator was set to 'N'.</p>
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Column Label	Description
Meets 42 CFR 455.20	Yes or No indicator to be set as follows: 'Y' is to be used for all letters that were sent in order to meet the federal requirements of 42 CFR 455.20. 'N' is to be used for all letters that were sent for purposes other than compliance with 42 CFR 455.20.

Member Region	The MCO Region where the Member resides. Reported as a two (2) character text string. Valid values are 01, 02, 03, 04, 05, 06, 07 and 08.
Billing Provider Type	Billing Provider Type is designated with a state specific two (2) character field. Example: Billing Provider Type 01 = General Hospital
MCO ICN	The MCO Internal Control Number used to identify the claim. To be reported as a text string.
Date of Contact	The date the MCO initiated the action. Letter = Date of the Letter
Contact Type	The type of communication the MCO used to contact the Member. Valid Codes are: L = Letter
Member Name	The name of the member that received the EOB letter.
Member Medicaid ID	The Medicaid ID of the Member contacted. To be reported as a text string.
Date of Service	Date of Service of claim
Service Code	The code (e.g. procedure code, revenue code) for the service that was rendered to the member.
Service Code Description	The description of the 'Service Code' for the service that was rendered to the member.
Payer	The name of the payer source. If the MCO paid the claim report MCO. If an MCO subcontractor paid the claim then list the service description of the Subcontractor (i.e. Pharmacy, Dental, Vision, PCP Cap)
Billing Provider Name	The name of the provider who has billed for service rendered.
Billing Provider Medicaid Number	The Medicaid ID number for the provider who has billed for service rendered.
Rendering Provider Name	The name of the provider who rendered the service to the member for that specific date of service.
Rendering Provider Medicaid Number	The Medicaid ID number for the provider who has rendered the service to the member.
Billed Amount	Total billed amount for the 'Service Code'.
Paid Amount	Total paid amount by the MCO or the MCO subcontractor for the 'Service code'.
Response	<p>If the Member has not responded then report 'No Member Response'. If the Member responded then concatenate the following: &lt;date of response&gt;,&lt;-&gt;,&lt;validation code&gt;. Validation codes are:</p> <p>RB = Received Benefit NB = No Benefit Received</p> <p>PB = Partial Benefit Received</p>
Action	<p>The Action the MCO took based on the Member's response. Multiple actions may be reported. Valid Actions are:</p> <p>NAT: No Action Taken</p> <p>IPI: Initiated Provider Investigation</p> <p>RPA: Requested Provider Billing Adjustment</p> <p>ARS: Accounts Receivable Setup to Recoup Payment</p>

Report #:	74(A)	Created:	10/19/2011
Name:	Medicaid Program Lock-In Reports/Admits Savings Summary Table	Last Revised:	05/14/2019
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The report lists the monthly savings for the total number of members admitted during the month and sub-categorized by the billing provider type codes.

**Sample Layout:**

Billing Provider Type Codes	Paid Amount		Savings YTD	Monthly Admits	Average Savings YTD
	1 Year Pre Lock-In	1 Month Post Lock-In			
Totals					

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Row Label	Description
Provider Type Codes	Provider type codes
Totals	The total sum of combined provider type codes in dollar amount

**Reporting Criteria:**

Column Label	Description
Billing Provider Type Codes	Listed are the different provider type codes to be utilized for this report.
Paid Amount	The paid amount is divided into two categories; (1) 1 Year Pre-LIP is the total paid amount for each provider type listed in the first column (Billing provider type codes) for the total number of members admitted one year prior to being assigned to the Lock-In Program ; (2) Is the <u>monthly</u> running YTD (year to date)of paid amounts for each provider type listed in the first column for the member after being assigned into the Lock-In Program <u>for the first year</u> from the MCO taking over the LIP. <u>After the first 12 months</u> , the second category will report the <u>1<sup>st</sup> year post – LIP</u> for each report month and yearly thereafter.(Example: column (2) will initially read 1 month post LI, then the next month it will read 2 month post ...through the first 12 months. After the first year, the second category will always list <b>1 year Post-LIP</b> for the month the report is generated.
Savings YTD	The total savings YTD for each provider type for the reporting period.
Monthly Admits	The total number of members that were placed into the Lock-In Program for the monthly reporting period.
Average Saving YTD	The average saving YTD (year to date) per member per month per provider type.(Savings YTD : Monthly admits = average savings YTD)



Report #:	74(B)	Created:	10/19/2011
Name:	Medicaid Program Lock-In Reports/Rolling Annual Calendar Comparison	Last Revised:	05/14/2019
Group:	Program Integrity	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The report lists the total savings created by the Lock-In Program reported on a quarterly basis.

**Sample Layout:**

Billing Provider Type Codes	Savings for 201? YTD				Total savings 201? YTD	Savings for 201? YTD				Total Savings 201? and 201? YTD	Notes/ Comments
	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter		
TOTALS:											

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Row Label	Description
Billing Provider Type Codes	Billing Provider type codes
Totals	The total sum of combined billing provider type codes in dollar amount

Column Label	Description
Billing Provider Type Codes	Billing Provider type codes
Savings for YTD (201?)	Savings for year to date totals
1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> , and 4 <sup>th</sup> quarters for year reported (201?)	The total savings for each provider type listed per calendar quarter of year reported.
Total Savings 201? YTD	The sum of the total savings for each provider type listed of year reported
Savings for YTD (201?)	Savings for year to date totals per quarter

1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> , and 4 <sup>th</sup> quarters for year reported (201?)	The total savings for each provider type listed per calendar quarter of year reported.
Total Savings 201? YTD	The sum of the total savings for each provider type listed of year reported
Notes/Comments	Additional Notes/Comments



Report #:	74(C)	Created:	10/19/2011
Name:	Medicaid Program Lock-In Reports/Member Initial Lock-In Effective Dates	Last Revised:	05/14/2019
Group:	Program Integrity	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The report lists the total number of members that have been admitted and discharged into the Lock-In Program for the month reported. The report also lists the total number of currently active member assigned to the Lock-In Program.

**Sample Layout:**

Monthly	Number of Members <b>Admitted</b> per Month	Number of Members <b>Discharged</b> per Month	Total Number of Members <b>Active</b> in LIP per Month	Notes/Comments
Total YTD				

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy
Row Label	Description
Year	The year listed for the reporting period.
Month	The individual month listed for the year for the reporting period.

Column Label	Description
Monthly Data	List the individual month for each reporting year.
Member	Member count of admitted/discharged/active members.

Number of Members <b>Admitted</b> per Month	The total number of members that have been admitted into the Lock-In Program during the monthly reporting period.
Number of Members <b>Discharged</b> per Month	The total number of members that have been discharged from the Lock-In Program during the monthly reporting period.
Total Number of Members <b>Active</b> in LIP per Month	The total number of members that are active or currently assigned to the Lock-In Program during the monthly reporting period.
Notes/Comments	Additional notes/comments



Report#:	75	Created:	09/01/2011
Name:	SUR Algorithms	Last Revised:	09/22/2011
Group:	Program Integrity		Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of the month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

#### Description:

The SUR Algorithm report identifies potential overpayments to providers determined to be erroneous, abusive or otherwise inconsistent with DMS and/or MCO policy. The report is to include only those providers for which a demand letter was sent.

MCO algorithms that are routinely run are to be identified, documented and provided to DMS prior to the first submission of the SUR Algorithms Report. If the MCO modifies and/or creates specially designed algorithms that are used in reporting any subsequent SUR Algorithm report, the MCO is to provide DMS at the time of report submission documentation related to the algorithm including the algorithm name, algorithm description and algorithm logic.

#### Sample Layout:

Program Integrity - SUR - Algorithms											
Medicaid Provider ID	Provider Name	Tax ID/SSN	Provider Type	Algorithm Name	Demand LTR Date	Review Period	Identified Overpayment	Disputed	Revised Overpayment	Collected Overpayment	Total Overpayment Collected
				sub-total for <Algorithm Name>:			\$0.00	0	\$0.00	\$0.00	\$0.00
				sub-total for <Algorithm Name>:			\$0.00	0	\$0.00	\$0.00	\$0.00
				sub-total for <Algorithm Name>:			\$0.00	0	\$0.00	\$0.00	\$0.00
				Total for all Algorithms:			\$0.00	0	\$0.00	\$0.00	\$0.00

#### Reporting Criteria:

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Algorithm Name' by 'Demand LTR Date' by 'Medicaid Provider ID'.

Row Label	Description
Sub-total for <Algorithm Name>:	A sub-total for the 'Identified Overpayment', 'Revised Overpayment', 'Collected Overpayment' and 'Total Overpayment Collected' columns for each 'Algorithm Name' is to be calculated for all reported activity.  A sub-total of all <Y> listed in the 'Disputed' column is to be calculated for all reported activity.

Total for all Algorithms:	<p>A total of all algorithm sub-totals is to be calculated for the 'Identified Overpayment', 'Revised Overpayment', 'Collected Overpayment' and 'Total Overpayment Collected' columns for all reported activity.</p> <p>A total of all algorithms sub-totals is to be calculated for the "Disputed" column for all reported activity.</p>
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Column Label	Description
Medicaid Provider ID	The Provider's Medicaid ID
Provider Name	Concatenate the Providers <Last Name>, <First Name>, Middle Initial>
Tax ID/SSN	The Provider's FEIN number or SSN
Provider Type	Concatenate <Billing Provider Type> - <Billing Provider Type Description>. Values for Provider Type are provided in Exhibit A: Billing Provider Type and Specialty Crosswalk.
Algorithm Name	The name and/or title designated to a specific algorithm.
Demand LTR Date	The letter and mailing date of the demand letter pertaining to a specific algorithm and Provider.
Review Period	The time span (dates-of-service) of claims reviewed for a specific algorithm.
Identified Overpayment	A potential overpayment amount identified through an algorithm as reported on the demand letter.
Disputed	<p>Valid codes are:</p> <p>Y = Demand Letter was Disputed</p> <p>N = Demand Letter was not Disputed</p>
Revised Overpayment	If the Demand Letter was disputed and the overpayment amount was changed then report the new overpayment amount. Otherwise report the overpayment amount as identified in the Demand Letter.
Collected Overpayment	The amount collected during the reporting period based on a specific algorithm demand letter.
Total Overpayment Collected	The total amount collected since the demand letter was sent through the end of the reporting period.



Report #:	76	Created:	09/01/2011
Name:	Provider Fraud Waste and Abuse Report	Last Revised:	4/9/19
Group:	Program Integrity	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

#### Description:

The Provider Fraud Waste and Abuse report should contain all cases that are in the initial (not reported on the TIPS report) investigation stages acted upon during the reporting period. New cases, existing case actions, and closed cases within the reporting period are to be identified and the outcome of the investigation documented based upon the most current DMS State Requirements regarding Detecting and Preventing Fraud, Waste and Abuse .

#### Sample Layout:

Provider Fraud Waste and Abuse-Active Cases																
PIU Case Number	Provider Name	Medicaid Provider ID	Provider NPI	Source of Complaint	OIG Case Number (if applicable)	Date Complaint or Referral Received	Date Case Opened	MAT Case (Y/N)	Summary of Complaint (with timeframe reviewed)	Initial Investigation (Y/N)	PIU Action(s) Taken and Date(s)	Referred to DMS (Y, N, E, NA-Reason)	Date Referred to DMS	Provider on Prepayment (Y/N) (Date if applicable)	Overpayment Identified	Date Case Closed (with Code)

#### Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Medicaid Provider ID'

Row Label	Description
NA	NA

Column Label	Description										
PIU Case Number	The unique number assigned by the MCO to identify the case.										
Provider Name	The specific name of the provider (individual, group or clinic) that the complaint was filed against.										
Medicaid Provider ID	Report the Medicaid Provider ID if an individual provider. Report the Medicaid Billing Provider ID if a Facility or group practice. ID is to be reported as a text string.										
Provider NPI	The Provider's NPI number reported as a text string.										
Source of Complaint	Valid codes are to be reported using the list below. Please note there may be multiple referral sources.  <table> <tr> <th>Code</th><th>Code Description</th></tr> <tr> <td>DMS</td><td>The Department for Medicaid Services</td></tr> <tr> <td>OIG</td><td>The Office of Inspector General</td></tr> <tr> <td>INT</td><td>MCO internal source such as hotline, algorithm, SIU, etc. The Internal source should be specified</td></tr> <tr> <td>OTH</td><td>MCO other source. Source should be identified</td></tr> </table>	Code	Code Description	DMS	The Department for Medicaid Services	OIG	The Office of Inspector General	INT	MCO internal source such as hotline, algorithm, SIU, etc. The Internal source should be specified	OTH	MCO other source. Source should be identified
Code	Code Description										
DMS	The Department for Medicaid Services										
OIG	The Office of Inspector General										
INT	MCO internal source such as hotline, algorithm, SIU, etc. The Internal source should be specified										
OTH	MCO other source. Source should be identified										
OIG Case Number	The number assigned to the case by OIG or N/A (Applicable only to OIG Source of Complaint). If the source of complaint is OIG, an OIG Case # is required in the OIG Case Number column.										
Date Complaint or Referral Received	The date the complaint or referral was received by the MCO.										
Date Case Opened	Date the case was opened for review by the MCO.										
MAT (Y or N)	Case involves Medication Assisted Treatment (Y- yes, N-no).										
Summary of Complaint with timeframe reviewed	Short description of the complaint and MCO insight regarding pertinent facts to case. The timeframe under review should be included.										
Initial Investigation (Y or N)	Initial Investigation (Y- yes, N-no). (The case has been opened and is being actively worked. If a case has been referred to DMS or submitted for closure it would not be in the initial investigation stage.)										
PIU Action(s) Taken and Date(s)	Brief description of tangible action(s) taken during the reporting period with corresponding date(s). If no action was taken, explain why.										
Referred to DMS (Y, N, E or N/A-Reason)	Investigative report was referred to DMS with MCO recommendation and the MCO requesting permission to take action. <table> <tr> <th>Code</th><th>Code Description</th></tr> <tr> <td>Y</td><td>Yes, case referred to DMS.</td></tr> <tr> <td>N</td><td>No, case has not been referred to DMS.</td></tr> <tr> <td>E</td><td>Extension Requested</td></tr> <tr> <td>N/A-Reason</td><td>Referral to DMS not applicable. The reason should be specified if the case was closed (not substantiated).</td></tr> </table>	Code	Code Description	Y	Yes, case referred to DMS.	N	No, case has not been referred to DMS.	E	Extension Requested	N/A-Reason	Referral to DMS not applicable. The reason should be specified if the case was closed (not substantiated).
Code	Code Description										
Y	Yes, case referred to DMS.										
N	No, case has not been referred to DMS.										
E	Extension Requested										
N/A-Reason	Referral to DMS not applicable. The reason should be specified if the case was closed (not substantiated).										
Date Referred to DMS	The date the action in the previous column was taken (N/A would only be applicable for No and N/A in previous column).										
Provider on Prepayment (Y/N) (Date if applicable)	Provider on Prepayment(Y- yes, N-no). If applicable, include the date the provider was placed on prepayment.										
Overpayment Identified	Amount identified during the investigation that may have resulted from fraud, waste and/or abuse. Please note any investigation involving any overpayment over the \$500 threshold must be referred to DMS prior to MCO action.										

Date Case Closed (with Code)	The Date the Case was closed or N/A. Please note if your MCO has referred the case to DMS <b>based upon a reasonable belief that fraud, waste or abuse has occurred</b> and if your MCO is not making tangible case updates every thirty (30) business days to the case the investigation should show as closed for purposes of the report and a notation made in the MCO case file. The code for these cases are as follows based upon the decision of DMS after submission of the MCO Standardized Investigative Report:								
	<table><tr><th>Code</th><th>Code Description</th></tr><tr><td>ICNA</td><td>Investigation Closed (no Action) with permission from DMS.</td></tr><tr><td>AC</td><td>Administrative Action Taken by MCO (no Fraud) with permission from DMS.</td></tr><tr><td>OIG</td><td>Acknowledgement from DMS case was referred for Preliminary Investigation.</td></tr></table>	Code	Code Description	ICNA	Investigation Closed (no Action) with permission from DMS.	AC	Administrative Action Taken by MCO (no Fraud) with permission from DMS.	OIG	Acknowledgement from DMS case was referred for Preliminary Investigation.
	Code	Code Description							
	ICNA	Investigation Closed (no Action) with permission from DMS.							
	AC	Administrative Action Taken by MCO (no Fraud) with permission from DMS.							
OIG	Acknowledgement from DMS case was referred for Preliminary Investigation.								



Report#:	77	Created:	10/02/2011
Name:	Member Fraud Waste and Abuse	Last Revised:	4/9/19
Group:	Program Integrity	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The Member Fraud Waste and Abuse report should contain all cases acted upon during the reporting period. New cases, action taken on existing cases, and closed cases are to be identified and the outcome of the investigation documented.

**Sample Layout:**

Member Fraud Waste and Abuse														
PIU Case Number	Medicaid Member ID	Member Name	Date Complaint or Referral Received	Source of Complaint	OIG Case Number (if applicable)	MAT Related (Y or No)	Date Case Opened	Summary of Complaint with timeframe reviewed	PIU Action(s) Taken with Date(s)	Initial Investigation (Y or N)	Overpayment Identified	Referred to DMS (Y, N, E or N/A-Reason)	Date Referred to DMS	Date Case Closed

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'Medicaid Member ID'

Row Label	Description
NA	NA

Column Label	Description
PIU Case Number	The unique number assigned by the MCO to identify the case.
Medicaid Member ID	Member's Medicaid ID reported as a text string.
Member Name	The name of the Medicaid member. Concatenate the Member's <Last Name>, <First Name> <Middle Initial>
Date Complaint or Referral Received	The date the complaint or referral was received by the MCO.

Source of Complaint	Valid codes are to be reported using the list below: <u>Code</u> <u>Code Description</u> DMS      The Department for Medicaid Services OIG      The Office of Inspector General INT      MCO internal source such as hotline, algorithm, SIU, etc. The Internal Source should be specified. OTH      MCO other source. Source should be specified.
OIG Case Number (if applicable)	The number assigned to the case by OIG or N/A (Applicable only to OIG Source of Complaint). If the source of complaint is OIG, an OIG Case # is required in the OIG Case Number column.
MAT Related (Y or No)	Case involves Medication Assisted Treatment (Y=yes, N=no).
Date Case Opened	Date the case was opened for review by the MCO.
Summary of Complaint with timeframe reviewed	Short description of the complaint with timeframe reviewed.
PIU Action(s) Taken with Date(s)	Brief description of tangible action(s) taken during the reporting period with corresponding date(s). If no action was taken, explain why.
Initial Investigation (Y or N)	Initial Investigation (Y=yes, N=no).
Overpayment Identified	Amount identified during the investigation that may have resulted from fraud, waste and/or abuse.
Referred to DMS (Y, N, E or N/A-Reason)	Investigative report was referred to DMS with MCO recommendation and the MCO requesting permission to take action. <u>Code</u> <u>Code Description</u> Y      Yes, case referred to DMS. N      No, case has not been referred to DMS. E      Extension Requested N/A-Reason      Referral to DMS not applicable. The reason should be specified if the case was closed (not substantiated).
Date Referred to DMS	The date the action in the previous column was taken (N/A would only be applicable for No and N/A in previous column)
Date Case Closed	The date the case was closed.

Report#:	78	Created:	08/23/2011
Name:	Quarterly Benefit Payments	Last Revised:	08/28/2012
Group:	Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	D, E, F
Period:	First day of quarter through the last day of quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

#### Description:

The Quarterly Benefit Payments report provides MCO financial activity for the Medicaid and Kentucky Children's Health Insurance Program (KCHIP) by MCO Region, Month and State Category of Service. Report only includes financial activity related to Benefits including claims, claim adjustments, mass adjustments, sub-capitation, and other financial payments/recoupment activity not processed as part of claims activity. Categories of Service are grouped by Medicaid Mandatory and Medicaid

Optional Services. Criteria to properly identify and report EPSDT services and KCHIP services are to be applied as outlined below.

#### Sample Layout:

MCO Data for LRC Quarterly Report					
Medicaid (non KCHIP) - Region 01					
COS	COS Description	mm/yyyy	mm/yyyy	mm/yyyy	Qtr. Total
<b>Medicaid Mandatory Services</b>					
02	Inpatient Hospital				\$0.00
12	Outpatient Hospital				\$0.00
	Subtotal: Mandatory Services	\$0.00	\$0.00	\$0.00	\$0.00

#### MedicaidOptionalServices

03	MentalHospital				\$0.00
04	Renal Dialysis Clinic				\$0.00
	Subtotal: Optional Services	\$0.00	\$0.00	\$0.00	\$0.00

Total: Mandatory and Optional Services	\$0.00	\$0.00	\$0.00	\$0.00
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Reinsurance				\$0.00
Pharmacy Rebates				\$0.00

Grand Total	\$0.00	\$0.00	\$0.00	\$0.00
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#### MCO Data for LRC Quarterly Report

##### KCHIP - Region 01

COS	COS Description	mm/yyyy	mm/yyyy	mm/yyyy	Qtr. Total
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#### Medicaid Mandatory Services

02	InpatientHospital				\$0.00
12	OutpatientHospital				\$0.00
	Subtotal: MandatoryServices	\$0.00	\$0.00	\$0.00	\$0.00

#### MedicaidOptionalServices

03	MentalHospital				\$0.00
04	Renal Dialysis Clinic				\$0.00
	Subtotal: Optional Services	\$0.00	\$0.00	\$0.00	\$0.00

Total: Mandatory and Optional Services	\$0.00	\$0.00	\$0.00	\$0.00
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Reinsurance				\$0.00
Pharmacy Rebates				\$0.00

Grand Total	\$0.00	\$0.00	\$0.00	\$0.00
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#### Reporting Criteria:

General Specifications	Definition
Financial Activity	Payments reported are to be based on date of payment.
EPSDT Services	Multiple Provider Types may provide EPSDT services. Reference Exhibit E for EPSDT Category of Service crosswalk for additional information regarding the identification of EPSDT services.
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Subtotal: Mandatory Services	Calculated Field: Total for all mandatory category of services listed in the report.
Subtotal: Optional Services	Calculated Field: Total for all optional category of services listed in the report.
Total: Mandatory and Optional Services	Calculated Field: Total of 'Subtotal: Mandatory Services' and 'Subtotal: Optional Services'.
Reinsurance	MCO premium payments for stop-loss insurance coverage.
Pharmacy Rebates	Drug Rebates collected by the MCO. 'Pharmacy Rebates' is to be reported as a negative value. Note: The state is responsible for collecting federal drug rebates.

Grand Total	Calculated Field: Total of 'Total: Mandatory and Optional Services', 'Reinsurance' and 'Pharmacy Rebates'.
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Column Label	Description
COS	Category of Service: State specific identification of services primarily identified by use of Provider Type. Reference Exhibit D for Category of Service crosswalk.
COS Description	Description for 'COS'
Medicaid (non-KCHIP)	The Medicaid population services are to be reported separately from the KCHIP population services. Populations to be included are based on the Medicaid Eligibility Groups (MEGs): <ul style="list-style-type: none"> <li>1. Dual Medicare and Medicaid</li> <li>2. SSI Adults, SSI Children and Foster Care</li> <li>3. Children 18 and Under</li> <li>4. Adults Over 18</li> </ul> Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
KCHIP	The Kentucky Children's Health Insurance Program (KCHIP) population services are to be reported separately from the Medicaid population services.
	Populations to be included are based on the Medicaid Eligibility Groups (MEGs): <ul style="list-style-type: none"> <li>3. MCHIP</li> <li>4. SCHIP</li> </ul> Reference Exhibit F for the Medicaid Eligibility Group crosswalk.
Region	Reporting of MCO Enrollee benefit payments is to be based on the Enrollee's region.

Report #:	79	Created:	01/09/2012
Name:	Health Risk Assessments	Last Revised:	05/31/2018
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

This Quarterly Report the MCO shall conduct initial Health Risk Assessments (HRA's) of New Members who have not been enrolled in the prior twelve (12) month period for the purpose, of accessing the Members need for any special health care needs. Enrollment period for new members begins when the MCO receives the member on an HIPAA 834. MCO shall list Health Risk Assessment (HRA's) of Cumulative Members. HRA's should be reported and broken out by Region.

**Sample Layout:**

Region	New HRA's Initiated Child	New HRA's Initiated Adult	New HRA's Initiated Pregnant Women	Total New HRA's	Cumulative HRA's Initiated Child	Cumulative HRA's Initiated Adult	Cumulative HRA's Initiated Pregnant Women	Total Cumulative HRA's Initiated
1								
2								
3								
4								
5								
6								
7								
8								
Total	0	0	0	0	0	0	0	0

**Reporting Criteria:**

Row Label	Definition
Region	Provide HRA data by each region.

Column Label	Description
Number of New HRA's Initiated Child (Total)	Provide the total number of New HRA's Initiated for children during the Quarter.
Number of New HRA's Initiated Adult (Total)	Provide the total number of New HRA's Initiated for Adults during this Quarter.
Number of New HRA's Initiated Pregnant (Total)	Provide the total number of New HRA's Initiated for pregnant women during the Quarter.
Total New HRA's Initiated	Provide the total number of New HRA's Initiated for this Quarter.
Number of Cumulative HRA's Initiated Child (Total)	Provide the total number of Cumulative HRA's Initiated for children during this Quarter.
Number of Cumulative HRA's Initiated Adult (Total)	Provide the total number of Cumulative HRA's Initiated for Adults during this Quarter.
Number of Cumulative HRA's Initiated Pregnant Women (Total)	Provide the total number of Cumulative HRA's Initiated for pregnant women during this Quarter .
Total Cumulative HRA's Initiated	Provide the total number of Cumulative HRA's Initiated for this Quarter.

Report#:	84	Created:	12/12/2011
Name:	QualityAssessmentandPerformanceImprovementProject	Last Revised:	
Group:	QualityAssuranceandImprovement	ReportStatus:	Active
Frequency:	Annual	Exhibits:	
Period:	Ongoing		
Due Date:	July31st		
Submit To:	KentuckyDepartmentforMedicaidServices		

**Description:**

The MCO's Quality Assessment and Performance Improvement (QAPI) Program shall conform to requirements of 42 CFR 438, Subpart D at a minimum. The MCO shall implement and operate a comprehensive QAPI program that assesses monitors, evaluates and improves the quality of care provided to Members. Behavioral Health services, the Contractor shall integrate Behavioral Health indicators into its QAPI program and include a systematic, on-going process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members. The program shall also have processes that provide for the evaluation of access to care, continuity of care, health care outcomes, and services provided or arranged for by the MCO. The Contractor's QI structures and processes shall be planned, systematic and clearly defined. Annually, the MCO shall submit the QAPI program description document to the Department for review by July 31 of each contract year.

Report#:	85	Created:	12/12/2011
Name:	QualityImprovementPlanandEvaluation	Last Revised:	
Group:	QualityAssuranceandImprovement	ReportStatus:	Active
Frequency:	Annual	Exhibits:	
Period:	Ongoing		
Due Date:	July31st		
Submit To:	KentuckyDepartmentforMedicaidServices		

**Description:**

The MCO's Quality Assessment and Performance Improvement (QAPI) Program shall monitor and evaluate the quality of health care on an ongoing basis and conform to requirements of 42 CFR 438, Subpart D at a minimum. Health care needs such as acute or chronic physical or behavioral conditions, high volume, and high risk, special needs populations, preventive care, and behavioral health shall be studied and prioritized for performance measurement, performance improvement and/or development of practice guidelines. Standardized quality indicators shall be used to assess improvement, assure achievement of at least minimum performance levels, monitor adherence to guidelines and identify patterns of over- and under-utilization. The measurement of quality indicators selected by the Contractor must be supported by valid data collection and analysis methods and shall be used to improve clinical care and services.

Annually, the MCO shall submit the Quality Improvement Plan and Evaluation document to the Department for review by July 31 of each contract year.



Report#:	86	Created:	01/09/2012
Name:	Annual Outreach Plan	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Annual	Exhibits:	

Period:	Ongoing		
Due Date:	July 31st		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The MCO shall develop, administer, implement, monitor and evaluate a Member and community education and outreach program that incorporates information on the benefits and services of the Contractor's Program to all Members. The Outreach Program shall encourage Members and community partners to use the information provided to best utilize services and benefits.

Educational and outreach efforts shall be carried on throughout the Contractor's Region. Creative methods will be used to reach Members and community partners. These will include but not be limited to collaborations with schools, homeless centers, youth service centers, family resource centers, public health departments, school-based health clinics, chamber of commerce, faith-based organizations, and other appropriate sites.

The plan shall include the frequency of activities, the staff person responsible for the activities and how the activities will be documented and evaluated for effectiveness and need for change.

Annually, the MCO shall submit the Annual Outreach Plan document to the Department for review by July 31 of each contract year.

**Sample Layout:**

Quality Improvement Activity	MCO Responsible Staff Person/People	Monitoring Frequency	Quarterly Activity Summary
Activity Name: Objective: Goal: Monitoring:			1st Quarter 20XX: 2nd Quarter 20XX: 3rd Quarter 20XX: 4th Quarter 20XX:
Activity Name: Objective: Goal: Monitoring:			1st Quarter 20XX: 2nd Quarter 20XX: 3rd Quarter 20XX: 4th Quarter 20XX:
Activity Name: Objective: Goal: Monitoring:			1st Quarter 20XX: 2nd Quarter 20XX: 3rd Quarter 20XX: 4th Quarter 20XX:

**Reporting Criteria:**

Row Label	Description
Activity Name	Provide the name of the QAPI Activity.
Objective	Provide the objective of the QAPI Activity.
Goal	Provide evaluation and track events and quality of care concerns.
Monitoring	Provide MCO staff person or committee responsible for monitoring.

Column Label	Description
Quality Improvement Activity	Provide the QAPI Activity along with objective, goal and monitoring for each activity.

MCO Staff Responsible Person or People	Provide the MCO staff person/people responsible for the QAPI activity.
Monitoring Frequency	Provide the monitoring frequency of each QAPI activity.
Quarterly Activity Summary	Provide the quarterly summaries of each QAPI activity

Report#:	90	Created:	10/29/2011
Name:	Performance Improvement Projects Proposal	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	N/A
Period:			
Due Date:	01-SEP		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The Performance Improvement Projects Proposal report provides the clinical or non-clinical focus areas for the annual performance improvement projects. The report is to be submitted based on the layout provided in the Health Plan Performance Improvement Project (PIP) document. The sections from the Health Plan Performance Improvement Project (PIP) document that are to be completed for submission of the Performance Improvement Projects Proposal report are:

Cover Page;  
MCO and Project Identifiers;  
MCO Attestation;  
Project Topic;  
Methodology; and  
Interventions.

Report#:	91	Created:	08/20/2011
Name:	Abortion Procedures	Last Revised:	08/29/2011
Group:	Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of quarter.		
Due Date:	15 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Claim listing of abortion procedures paid by the MCO within a quarter. In the event that no procedures were paid for during the reporting period, the report is still required to be provided. Attachments to be provided with the report include:

Claim Form  
Pre-op and/or Post-op Notes  
Physician Certificate  
Remittance Advice

The Department for Medicaid Services keeps all originals and provides CMS a copy of the Abortion Procedures Report, along with copies of all attachments stamped CONFIDENTIAL with confidential information redacted (except the last four numbers of the SS# as required by CMS).

**Sample Layout:**

Abortion Procedures							
MCO Region	Member ID	Member DOB	Provider NPI	Claim ICN	First DOS	Last DOS	Paid Amount

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy
Sort Order	The report is to be sorted in ascending order by 'MCO Region' by 'Member ID' by 'First DOS'.

Row Label	Description
Sub-total	Although not shown on the report template, a subtotal line is to be added after each Region. Sub-total figures are to be reported for Medicaid ID, Claim ICN and Paid Amount columns. Definition for each calculation is the same as listed for the 'Total' but limited to the Region.
Total	Medicaid ID: Total unduplicated Member IDs for the reporting period. Claim ICN: Total count of all claim ICNs for the reporting period. Paid Amount: Total payments for all procedures for the reporting period

Column Label	Description
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MCO Region	The MCO Region is determined by the Member's county at the time the service was provided. The MCO shall be under contract to provide Medicaid services in the Region reported. Valid region codes are 01, 02, 03, 04, 05, 06, 07, and 08.
Member ID	The Member's Medicaid ID.
Member DOB	The Member's date of birth.
Provider NPI	The Provider's NPI number as reported on the claim.
Claim ICN	The MCO claim internal control number for the claim being reported.
First DOS	First date of service as reported on the claim.
Last DOS	Last date of service as reported on the claim.
Paid Amount	The total adjudicated claim paid amount by the MCO. Example: A claim adjudicated to pay \$100. There is an outstanding A/R in financial for \$200. The MCO should report the \$100 adjudicated paid amount and not the \$0 financial payment.

Report #:	92	Created:	10/29/2011
Name:	Performance Improvement Projects Measurement	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	N/A
Period:			
Due Date:	01-SEP		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The Performance Improvement Projects Measurement report provides the baseline, interim, and final results of the Performance Improvement Projects.

The baseline report is to be submitted in the format as outlined in the Health Plan Performance Improvement Project (PIP) document.

The interim report is to be submitted in the format as outlined in the Health Plan Performance Improvement Project (PIP) document.

The final report is to be submitted in the format as outlined in the Health Plan Performance Improvement Project (PIP) document.

A Project Review Guidelines is provided as a separate document which outlines how the PIPs will be evaluated and also provides guidance to the plans on what is expected through the PIP lifetime. The actual scoring of a PIP may differ based on the EQRO contracted with the Department.

Report #:	93	Created:	11/08/2011
Name:	EPSDT CMS-416	Last Revised:	
Group:		Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	Federal Fiscal Year: 01-OCT through 30-SEP		
Due Date:	15-MAR		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The EPSDT CMS-416 report is required annually. The specifications for the EPSDT CMS-416 report shall be in compliance with the most current CMS-416: Annual EPSDT Participation Report and shall be based on Federal Fiscal Year (FFY).

Report #:	94	Created:	11/08/2011
Name:	Member Surveys	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	Calendar Year: 01-JAN through 31-DEC		
Due Date:	31-AUG		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The Contractor shall conduct an annual survey of Members' satisfaction with the quality of services provided and their degree of access to services. The member satisfaction survey requirement shall be satisfied by the Contractor participating in the Agency for Health Research and Quality's (AHRQ) current Consumer Assessment of Healthcare Providers and Systems survey ("CAHPS") for Medicaid Adults and Children, administered by an NCQA certified survey vendor. The Contractor shall provide a copy of the current CAHPS survey tool to the Department. Annually, the Contractor shall assess the need for conducting special surveys to support quality/performance improvement initiatives that target subpopulations perspective and experience with access, treatment and services. The Department shall review and approve any Member survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used conducting the Member or other special surveys, the number and percentage of the Members to be surveyed, response rates, and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.

Report#:	95	Created:	11/08/2011
Name:	Provider Surveys	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	Calendar Year: 01-JAN through 31-DEC		
Due Date:	31-AUG		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The Contractor shall conduct an annual survey of Providers' satisfaction. To meet the provider satisfaction survey requirement the Contractor shall submit to the Department for review and approval the Contractor's provider satisfaction survey tool. The Department shall review and approve any Provider survey instruments and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results. A description of the methodology to be used conducting the Provider or other special surveys, the number and percentage of the Providers to be surveyed, response rates, and a sample survey instrument, shall be submitted to the Department along with the findings and interventions conducted or planned.

Report#:	96	Created:	11/08/2011
Name:	Audited HEDIS Reports	Last Revised:	
Group:	Quality	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	Calendar Year: 01-JAN through 31-DEC		
Due Date:	31-AUG		
Submit To:	National Committee for Quality Assurance (NCQA) Kentucky Department for Medicaid Services		

**Description:**

The Contractor shall be required to collect and report HEDIS data annually. After completion of the Contractor's annual HEDIS data collection, reporting and performance measure audit, the Contractor shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization and an electronic (preferred) or printed copy of the interactive data submission system tool (formerly the Data Submission tool) by no later than August 31st.

In addition, for each measure being reported, the Contractor shall provide trending of the results from all previous years in chart and table format. Where applicable, benchmark data and performance goals established for the reporting year shall be indicated. The Contractor shall include the values for the denominator and numerator used to calculate the measures.

For all reportable Effectiveness of Care and Access/Availability of Care measures, the Contractor shall stratify each measure by Medicaid eligibility category, race, ethnicity, gender and age.

Report#:	97	Created:	10/08/11
Name:	Behavioral Health Adult and Children Populations	Last Revised:	02/05/16
Group:	Behavioral Health	Report Status:	Active
Frequency:	Quarterly, SFY to date	Exhibits:	G
Period:	First day of the State Fiscal Year quarter through the last day of the State Fiscal Year quarter		
Due Date:	30 calendar days following the last day of the reporting period		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Kentucky Department for Medicaid Services		

**Description:**

The report identifies the behavioral health populations to whom services have been provided during the reporting period. Reference Exhibit G for definitions of behavioral health populations. **The populations in this report should be consistent with the populations across all reports.** Count an individual as an adult if at any time during the reporting period the individual was 18 years old or older. Specific sections of this report require a look back of 24 months from the quarter end date of the reporting period. **Both paid and denied claims should be counted when determining if a service has been rendered.**

**The populations determined on this report shall be used as the populations for Reports 103, 104, 105, 106 and 110.**

**Sample Layout:**

QEmm/dd/yyyy	
Unduplicated Client Count	Percent of MCO Enrolled
<b>MCO Enrolled</b>	<b>1.00</b>
<b>BH Adults &amp; Children Enrolled</b>	
<b>ADULTS</b>	
All MCO Adults Enrolled	
Adults enrolled during reporting period with BH Diagnosis in 24 months before Qtr End but no BH Services during Reporting Period (1)	
Adults enrolled during the reporting period with BH Diagnosis and BH Services during Reporting Period (2)	
BH Adults General Population [Sum of (1) and (2) above]	
Adults with No BH Diagnosis during 24 months prior to Qtr End who did receive BH Services during Reporting Period	
SMI Enrolled (Subset of BH Adults General Population)	

<b>CHILDREN/YOUTH</b>		
All MCO Children/Youth Enrolled		

Children enrolled during the reporting period with BH Diagnosis in 24 months before Qtr End but no BH Services during Reporting Period (1)		
Children enrolled during the reporting period with BH Diagnosis and BH Services during Reporting Period (2)		
BH Children General Population [Sum of (1) and (2) above]		
Children with No BH Diagnosis who received BH Services during reporting period		
SED Enrolled. (Subset of BH Children General Population)		

<b>SPECIAL POPULATIONS – Subset of Above</b>		
All Pregnant and Post Partum Women		
Adults (18+) - Pregnant and Post Partum Women		
Children/Youth (<18) - Pregnant and Post Partum Women		
All BH Clients Receiving EPSDT Services		
Adults (18+) - BH Clients Receiving EPSDT Services		

Children/Youth (<18) - BH Clients Receiving EPSDT Services		
All PRTF I Clients		
Adults (18+) - PRTF I Clients - in state		
Adults (18+) - PRTF I Clients - out of state		
Children/Youth (<18) - PRTF I Clients - in state		
Children/Youth (<18) - PRTF I Clients - out of state		

**Reporting Criteria:**

General Specifications	Definition
DateFormat	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy  Quarterly Unduplicated count of all Members from the first day of the State Fiscal Year quarter to the last day of the State Fiscal Year quarter.

	State Unduplicated count of Members from the first day of the State Fiscal Year through the last day of the State Fiscal Year (July 1- Year June 30).
Percent	Report percentages as decimals, e.g., 5.25% should be reported as .0525.
SortOrder	The report is to be sorted in order as shown above in sample layout.

Row Label	Description
MCO Enrolled	Include all persons who were members during the reporting period.
BH Adults and Children/Youth Enrolled	An unduplicated count of MCO enrolled members who meet the criteria for any of the four Behavioral Health populations according to Exhibit G.
<b>Adults</b>	This is a header row
All MCO Adults Enrolled	An unduplicated count of all MCO enrolled Members that are age 18 or older.
Adults with BH Diagnosis not receiving BH services	An unduplicated count of all MCO Members enrolled during the reporting period that meet the criteria outlined in Measure 1 in Exhibit G. This is a subset of the row "All MCO Adults Enrolled".
Adults with BH Diagnosis receiving BH Services	An unduplicated count of all MCO Members enrolled during the reporting period that meet the criteria outlined in Measure 2 in Exhibit G. This is a subset of the row "All MCO Adults Enrolled".
TOTAL BH ADULTS	The sum of the previous two rows
Adults without BH Diagnosis receiving BH Services	An unduplicated count of all MCO enrolled Members without a diagnosis as outlined in Exhibit G who received a behavior health service. Refer to the Fee for Service Schedules to identify behavioral health services.
SMI Enrolled	An unduplicated count of all MCO users that are SMI. The SMI Behavioral Health Population is defined in Exhibit G: Behavioral Health Populations. This is a subset of row "BH Adults Enrolled".
<b>Children/Youth</b>	This is a header row
All MCO Children/Youth Enrolled	An unduplicated count of all MCO enrolled Members that are under age 18.
Children/Youth with BH Diagnosis not receiving BH Services	An unduplicated count of all MCO Members enrolled during the reporting period that meet the criteria outlined in Measure 1 in Exhibit G. This is a subset of the row "All MCO Children/Youth Enrolled".
Children/Youth with BH Diagnosis receiving BH Services	An unduplicated count of all MCO Children/Youth enrolled during the reporting period that meet the criteria outlined in Measure 2 in Exhibit G. This is a subset of the row "All MCO Children/Youth Enrolled".
TOTAL BH Children/Youth	The sum of the previous two rows
Children/Youth without BH Diagnosis receiving BH Services	An unduplicated count of all MCO enrolled Children/Youth that meet the criteria outlined in Exhibit G.
SED Enrolled	An unduplicated count of all MCO users that are SED. The SED Behavioral Health Population is defined in Exhibit G: Behavioral Health Populations. "This is a subset of "BH Children/Youth Enrolled".
<b>SPECIAL POPULATIONS</b>	This is a header row
<b>Pregnant and Postpartum Women</b>	This is a header row
All Pregnant and Postpartum Women	The unduplicated count of pregnant or postpartum members for which a behavioral health service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify behavioral health services. This row is the sum of the following two rows which distinguish between adults and children/youth.
Adults (18+) – Pregnant and Postpartum Women	The unduplicated count of pregnant or postpartum members that are age 18 or older for which a behavioral health service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify behavioral health services. This row is a subset of the row "All Pregnant and Postpartum Women".

Children/Youth(<18) – Pregnant and Postpartum Women	The unduplicated count of pregnant or postpartum members that are less than 18 years old for which a behavioral health service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify behavioral health services. Refer to industry
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	standards for a list of behavioral health services. This row is a subset of the row “All Pregnant and Postpartum Women”.
<b>EPSDT Service Recipients (BH)</b>	This is a header row
All BH Clients Receiving EPSDT Services	The unduplicated count of behavioral health members for which an EPSDT service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify EPSDT services. This row is the sum of the following two rows which distinguish between adults and children/youth.
Adults (18+) – BH Clients Receiving EPSDT Services	The unduplicated count of behavioral health members that are age 18 or older for which an EPSDT service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify EPSDT services. This row is a subset of the row “All BH Clients Receiving EPSDT Services”.
Children/Youth (<18) – BH Clients Receiving EPSDT Services	The unduplicated count of behavioral health members that are less than 18 years of age for which an EPSDT service was provided by the MCO or the MCO subcontractor during the reporting period. Refer to the Fee for Service Schedules to identify EPSDT services. This row is a subset of the row “All BH Clients Receiving EPSDT Services”.
<b>PRTF I Clients</b>	This is a header row
All BH Clients Receiving Services at a PRTF I Facility	The unduplicated count of members served at any PRTF I facility by the MCO or the MCO subcontractor during the reporting period. This row is the sum of the following four rows which distinguish between adults and children/youth and between in state and out of state facilities.
Adults (18+) – BH Clients Receiving Services at a PRTF I Facility In State	The unduplicated count of members that are age 18 and older served at any Kentucky PRTF I facility by the MCO or the MCO subcontractor during the reporting period. This row is a subset of the row “All BH Clients Receiving Services at a PRTF I Facility”.
Adults (18+) – BH Clients Receiving Services at a PRTF I Facility Out of State	The unduplicated count of members that are age 18 and older served at any PRTF I facility outside of Kentucky by the MCO or the MCO subcontractor during the reporting period. This row is a subset of the row “All BH Clients Receiving Services at a PRTF I Facility”.
Children/Youth (<18) – BH Clients Receiving Services at a PRTF I Facility In State	The unduplicated count of members that are less than age 18 served at any Kentucky PRTF I facility by the MCO or the MCO subcontractor during the reporting period. This row is a subset of the row “All BH Clients Receiving Services at a PRTF I Facility”.
Children/Youth (<18) – BH Clients Receiving Services at a PRTF I Facility Out of State	The unduplicated count of members that are less than age 18 served at any PRTF I facility outside of Kentucky by the MCO or the MCO subcontractor during the reporting period. This row is a subset of the row “All BH Clients Receiving Services at a PRTF I Facility”.

Column Label	Description
QE mm/dd/yyyy	Quarter Ending (QE) is the last day of the State Fiscal Year quarter displayed in the format mm/dd/yyyy. This column is to be populated in all reports in space provided; contents should apply to the last quarter ending and the quarter ending date should be correctly displayed in the space provided.  Quarter Unduplicated count of all users from the first day of the quarter to the last day of the quarter of the State Fiscal Year.



Report #:	119	Created:	01/19/12
Name:	Mental Health Statistics Improvement Project Adult Survey Report	Last Revised:	2/12/2015
Group:	Behavioral Health	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	State Fiscal Year: 07/01 through 06/30		
Due Date:	180 days after State Fiscal Year End		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities		
	Kentucky Department for Medicaid Services		

#### Description:

The MCO shall annually implement the Mental Health Statistics Improvement Program (MHSIP) Adult Survey. The behavioral health member satisfaction survey requirement shall be satisfied by the Contractor by administering the 28-Item Mental Health Statistics Improvement Program (MHSIP) Adult Survey plus eight (8) additional items for the Social Connectedness and Functioning National Outcome Measures (for adult behavioral health members).

The MCO may contact the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to obtain a current version of the survey tools. The Contractor shall submit a plan for administration (sampling strategy, survey methodology, etc.) to DBHDID prior to survey administration. DBHDID shall review and approve any behavioral health member survey instruments and plan for administration and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results in the format prescribed. Survey results shall include counts of Members surveyed by MCO Region and report percentages of Members who report positively about the following domains:

Access  
 Quality and Appropriateness  
 Outcomes  
 Treatment Planning  
 General Satisfaction with Services

**Sample Layout:**

Provider Type	SFY Survey Completed	General Satisfaction	Access	Quality	Participation	Outcomes	Social Connectedness	Functioning

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Provider Type	All Billing Provider Types are to be considered. Billing Provider Type is designated with a state specific two (2) character field. Crosswalk of Provider Type and Provider Specialty to each Provider Description is provided in Exhibit A: Provider Type and Specialty Crosswalk.
SFY Survey Completed	The State Fiscal Year within which the survey was completed. Use format YYYY.
General Satisfaction	The Mean Score of the domain.
Access	The Mean Score of the domain.
Quality	The Mean Score of the domain.
Participation	The Mean Score of the domain.
Outcomes	The Mean Score of the domain.
Social Connectedness	The Mean Score of the domain.
Functioning	The Mean Score of the domain.

Report #:	120	Created:	01/19/12
Name:	Youth Services Satisfaction Caregiver Survey Report	Last Revised:	2/12/2015
Group:	Behavioral Health	Report Status:	Active
Frequency:	Annual	Exhibits:	
Period:	State Fiscal Year: 07/01 through 06/30		
Due Date:	180 days after the end of State Fiscal Year		
Submit To:	Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities		
	Kentucky Department for Medicaid Services		

**Description:**

The MCO shall annually implement the Youth Services Satisfaction Caregiver Survey (YSSF) . The YSSF requirement shall be satisfied by the Contractor by administering the 21-item Youth Services Survey Family Version (YSS-F) plus additional 4 items for the Social Connectedness National Outcome Measure (for parents /caregiver of child members). The Contractor may contact the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) to obtain a current version of the survey tools. The MCO shall submit a plan for administration (sampling strategy, survey methodology, etc.) to DBHDID prior to survey administration. DBHDID shall review and approve any Behavioral Health member survey instruments and plan for administration and shall provide a written response to the Contractor within fifteen (15) days of receipt. The Contractor shall provide the Department a copy of all survey results in the format prescribed. Survey results shall include counts of Members surveyed by MCO Region and report percentages of Youth Members who report positively about the following domains:

Access  
 Outcomes  
 Treatment Planning  
 Family Members Reporting high Cultural Sensitivity of Staff  
 General Satisfaction with Services

**Sample Layout:**

Provider Type	SFY Survey Completed	General Satisfaction	Access	Cultural Sensitivity	Participation	Outcomes	Social Connectedness	Functioning

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy
Provider Type	All Billing Provider Types are to be considered. Billing Provider Type is designated with a state specific two (2) character field. Crosswalk of Provider type and Provider Specialty to each Provider Description is provided in Exhibit A: Provider Type and Specialty Crosswalk.
SFY Survey Completed	The State Fiscal Year within which the survey was completed. Use format YYYY.
General Satisfaction	The Mean Score of the domain.
Access	The Mean Score of the domain.
Cultural Sensitivity	The Mean Score of the domain.
Participation	The Mean Score of the domain.
Outcomes	The Mean Score of the domain.
Social Connectedness	The Mean Score of the domain.
Functioning	The Mean Score of the domain.



Report#:	126	Created:	08/28/2012
Name:	FQHC and RHC	Last Revised:	02/27/2013
Group:	Utilization	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of the quarter through the last day of the quarter.		
Due Date:	45 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The FQHC and RHC report provides the total amount paid to each Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) per month. All Providers with a specialty of FQHC or RHC are to be reported.

**Sample Layout:**

Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) Utilization								
Specialty	Provider Medicaid ID	Provider Name	Month	# Unduplicated Claims Excluding Crossovers	Total Amt Paid- Claims Excluding Crossovers	TPL Amount Listed	# Unduplicated Crossover Claims	Total Amt Paid - Crossover Claims

**Reporting Criteria:**

General Specifications	Definition
Sort Order	The report is to be sorted in ascending order: <Specialty> by <Provider Medicaid ID> by <Month>

Row Label	Description
NA	

Column Label	Description
Specialty	The Provider specialty. Valid values are FQHC and RHC
Provider Medicaid ID	Medicaid ID assigned by the Department
Provider Name	Provider name associated with the Provider Medicaid ID as listed in MMIS
Month	The month that the payments were made to the Provider. Format to be reported is <YYYY/MM>.
# Unduplicated Claims Excluding Crossovers	Total number by Medicaid ID of unduplicated claims for the quarter. Do not include Crossover Claims
Total Amt Paid- Claims Excluding Crossovers	Total dollars paid for the total number of unduplicated claims excluding crossovers listed in the previous column.
TPL Amount Listed	Total amount of any Third Party payment listed for the number of unduplicated claims excluding crossovers listed in column three.
# Unduplicated Crossover Claims	Total number by Medicaid ID of unduplicated crossover claims for the quarter.
Total Amt Paid - Crossover Claims	Total dollars paid for the total number of unduplicated crossover claims listed in the previous column.

Report#:	127	Created:	08/28/2012
Name:	Statement on Standards for Attestation Engagements (SSAE) No. 16	Last Revised:	NA
Group:	Audit/Internal Control	Report Status:	Active
Frequency:	Annual or as Appropriate	Exhibits:	NA
Period:	As required by APA		
Due Date:	30 days following the first calendar quarter (April 30)		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

MCO should provide the Statement on Standards for Attestation Engagements (SSAE) No. 16 Type II audit that addresses the engagements conducted by services providers on service organization for reporting design control and operational effectiveness.

Report#:	173	Created:	07/12/2018
Name:	MCO-PBM Compliance Report for POS Transactions	Last Revised:	
Group:	Pharmacy	Report Status:	Active
Frequency:	Annual	Exhibits:	NA
Period:	State Fiscal Year July 1 – June 30.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

Monthly summary of Ownership & Related Entities with details for each MCO, PBM and the related entities; Monthly Financial Detail; Cumulative Financial Detail; Related Entity Financial Detail; Related Entity Financial Detail; Pharmacy Type Financial Detail. List Executive Staff Titles; Relationship Titles; MCO and the PBM shall each submit a legal structure chart.

**Sample Layout:**

Ownership and Related Entities of the PBM

MCO Disclosure

ENTER ON SHEET 2

MCO Name

Address 1

Address 2

City

State

Zip Code

Phone

email

Subsidiaries

Relationship to MCO

MCO Officers/Ownership

Name

Title

PBM Disclosure

		Relationship to PBM	
		PBM Parent	
PBM Name			
Address 1			
Address 2			
City			
State			
Zip Code			
Phone			
email			

PBM Officers/Ownership	
Name	Title

Related Entities of the PBM

		Relationship to PBM
Entity Name		
Address 1		
Address 2		
City		
State		
Zip Code		
Phone		
email		
Business Type		
		Relationship End Date (if applicable)

Related Entities of the PBM Officers/Ownership

Name	Title	Detail for "Other"

Monthly PBM Financial Detail

MCO  
Name: \_\_\_\_\_

Report Run  
Date: \_\_\_\_\_

Reporting  
Period  
From: \_\_\_\_\_

Reporting  
Period To: \_\_\_\_\_

NOTE: See "Data Dictionary and Terminology" tab for detail on reporting items.

Jan 2017 Financial Information

Item #

1	Medicaid \$ paid to PBM	\$ -
2	Medicaid \$ paid to PBM, not paid to pharmacies	\$ -

		Ingredient Cost		Dispensing Fee		Other Fees		total claims
		median	mean	median	mean	median	mean	
3	Average reimbursement by claim, PBM to pharmacies of common ownership	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0
4a	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills up to a 34 days supply	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0
4b	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills greater than a 34 days supply	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0
5a	Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills up to a 34 days supply	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0
5b	Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills greater than a 34 days supply	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0

6	Total remuneration fees charged to pharmacies of common ownership, by fee type	DI Fees	Other Assessments /Charges
		\$ -	\$ -
7	Total remuneration fees charged to pharmacies with 11 or more locations, by fee type	\$ -	\$ -
8	Total remuneration fees charged to pharmacies with 10 or fewer locations, by fee type	\$ -	\$ -

2017 Cumulative Financial Detail

MCO  
Name: \_\_\_\_\_

Report Run  
Date: \_\_\_\_\_

Reporting  
Period From: \_\_\_\_\_

Reporting  
Period To: \_\_\_\_\_

NOTE: See "Data Dictionary and Terminology" tab for detail on reporting items.

Item #

1	Medicaid \$ paid to PBM	\$ -
2	Medicaid \$ paid to PBM, not paid to pharmacies	\$ -

		Ingredient Cost		Dispensing Fee		Other Fees		total claims
		median	mean	median	mean	median	mean	
3	Average reimbursement by claim, PBM to pharmacies of common ownership	\$ 0		\$ -	\$ -	\$ -	\$ -	
4a	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills up to a 34 days supply	\$ 0	\$ -	\$ -	\$ -	\$ -	\$ -	
4b	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills greater than a 34 days supply	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
5a	Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills up to a 34 days supply	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
5b	Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills greater than a 34 days supply	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	

6	Total remuneration fees charged to pharmacies of common ownership, by fee type	DI Fees	Other Assessments /Charges
		\$ -	\$ -



Jan 2017								
Average reimbursement by claim from PBM to pharmacies by pharmacy type						Total assessments charged to pharmacies by pharmacy type		
Ingredient Cost		Dispensing Fee		Other Fees				
Pharmacy Type	median	mean	median	mean	median	mean	DI Fees	Other Assessments /Charges
Specialty								
Mail Order / Home Delivery								
LTC / Institutional								
Maintenance Supply (≥ 90 DS)								

Addendum 1

Kentucky Department for Medicaid Services

#173\_MCO-PBM Compliance Report for POS Transactions

Executive Staff Titles

Behavioral Health Director

Board Member (Board of Directors) Chairman

(Board of Directors)

Chief Accounting Officer

Chief Administrative Officer

Chief Business Development Officer

Chief Business Officer

Chief Commercial Officer

Chief Compliance Officer

Chief Data Officer

Chief Executive

Chief Executive Officer

Chief Financial Officer

Chief Information Officer

Chief Information Security Officer

Chief Investment Officer

Chief Marketing Officer

Chief Medical Director

Chief Medical Officer

Chief Networking Officer

Chief of Staff

Chief Operations Officer

Chief Pharmaceutical Officer

Chief Privacy Officer

Chief Procurement Officer

Chief Revenue Officer

Chief Security Officer

Chief Technical Officer

Deputy General Manager

Deputy President

Director

Executive Chairman

Executive Vice President

Finance Director

Financial Control Officer

General Manager

Operations Director

Other Executive Staff

Owner

Partner

President

Proprietor

Senior Executive Vice President

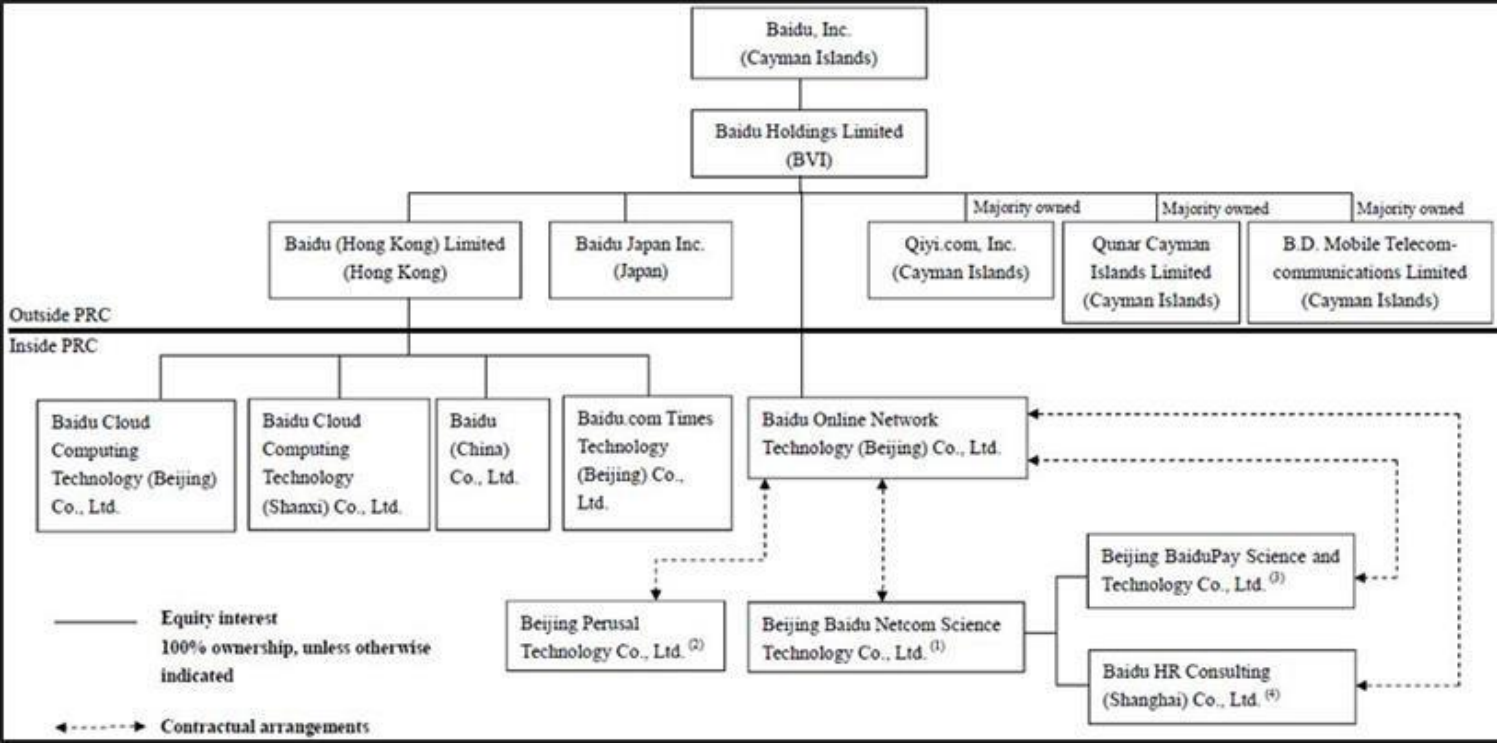
Senior Vice President

Vice Chairman (Board of Directors)

Vice President

Addendum 2

Kentucky Department for Medicaid Services	
#173, MCO-PBM Compliance Report for POS Transactions	
Relationship Titles	
MCO Holding Company Other	
Parent Co-Subsidiary	
Parent Jointly Held Companies PBM Jointly	
Held Companies PBM Management Company	
PBM Parent Company	
PBM Subsidiary Subcontractor/Vendor	
Wholly-owned Subsidiary	



Reporting Period From: \_\_\_\_\_  
Reporting Period To: \_\_\_\_\_

Item #

1	Medicaid \$ paid to PBM	\$ -
2	Medicaid \$ paid to PBM, not paid to pharmacies	\$ -

		Ingredient Cost		Dispensing Fee		Other Fees		
		median	mean	median	mean	median	mean	total claims
3	Average reimbursement by claim, PBM to pharmacies of common ownership	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
4a	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills up to a 34 days supply	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
4b	Average reimbursement by claim, PBM to pharmacies with 11 or more locations for fills greater than a 34 days supply							
5a	Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills up to a 34 days supply	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
5b		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Average reimbursement by claim, PBM to pharmacies with 10 or fewer locations for fills greater than a 34 days supply		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
6	Total remuneration fees charged to pharmacies of common ownership, by fee type	DI Fees		Other Assessments /Charges				
		\$ -		\$ -				
7	Total remuneration fees charged to pharmacies with 11 or more locations, by fee type	\$ -		\$				
8	Total remuneration fees charged to pharmacies with 10 or fewer locations, by fee type	\$ -		\$ -				

Kentucky Department for Medicaid Services

#173\_MCO-PBM Compliance Report for POS Transactions

Instructions

Tab 1: *Instructions: Read Only.*

Tab 2: *Report ID Information: Enter the identifying information for your organization.*

<b>Tab 3:</b>	<p><b>Ownership &amp; Related Entities:</b> Enter the details for each MCO, PBM, and the related entities.</p> <ul style="list-style-type: none"> <li>Managed care health plans should replicate their information on the Annual Disclosure of Ownership form as submitted to the Kentucky Department for Medicaid Services' Provider Enrollment Department.</li> <li>To identify the officers/ownership for the entities of the PBM, include all national level and state level contacts.</li> <li>The <b>"Toggle Utilities" button</b> at the top right hand corner of the tab, should be utilized for additional "Related Entities" and "Officers/Ownership" information.</li> <li>Input information for all shaded cells.</li> <li>Use drop-down menus to complete "Relationship Type" and "Executive Titles".</li> </ul>
<b>Tab 4:</b>	<b>Monthly Financial Detail:</b> Enter the monthly financial details by month and entity.
<b>Tab 5:</b>	<b>Cumulative Financial Detail:</b> This tab self populates; you do not need to enter information on this tab.
<b>Tab 6:</b>	<b>Related Entity Financial Detail:</b> Enter the monthly financial details by month and entity for the Kentucky Medicaid dollars spent.
<b>Tab 7:</b>	<b>Pharmacy Type Financial Detail:</b> Enter the monthly financial details by month and pharmacy type for the Kentucky Medicaid dollars spent.
<b>Tab 8:</b>	<b>Data Dictionary and Terminology.</b>
<b>Tab 9:</b>	<b>Addendum 1_Executive Staff Titles.</b>
<b>Tab 10:</b>	<b>Addendum 2_Relationship Titles.</b>
<b>Tab 11:</b>	<b>Addendum 3_Example_Legal Structure Chart:</b> The MCO and the PBM are shall each submit a legal structure chart.
<b>NOTES:</b>	<ol style="list-style-type: none"> <li>Reporting data should be at the <b>date of service</b> level.</li> <li>All dates must be entered in the following format: <b>mm/dd/yyyy</b>.</li> <li>When data is complete and accurate, save this workbook under the following: <b>MCOName_PBM Compliance Report_Calendar Year (yyyy)</b>.</li> <li>Transmit completed workbook to the Kentucky Department for Medicaid Services via <b>SharePoint</b>.</li> <li>For each new report that is submitted, the previous reported months of data will need to be refreshed.</li> <li>The macro security will need to be set to <b>"enable all macros"</b> in order to use this template.</li> </ol>
<b>REPORT DUE DATE:</b>	This report will be due by the 15th of the calendar month following the report period calendar month/year.



Reporting Criteria:

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA
Column Label	Description
#	Counter to easily identify record.
MemberLastName	The Member's last name.
MemberFirstName	The Member's first name.
SSN	Social Security Number of the Medicaid Member. To be reported as a 9 character text string without any dashes.
MedicaidID#	The Members Medicaid ID. To be reported as a text string.
SecondaryID	The Members MCO assigned ID number (Optional)
MCOEffectiveDate	The Effective Date of the MCO assignment that the MCO believes to be invalid.
MCOEnd Date	The End Date of the MCO assignment that the MCO believes to be invalid.
County	The three digit county code of the Member to be reported as a 3 character text string.
Program Code	The Member's one or two character Program Code that corresponds to the assignment that the MCO believes to be invalid. To be reported as a text string.
StatusCode	The Member's two character Status Code that corresponds to the assignment that the MCO believes to be invalid. To be reported as a text string.
DataElement#1	Member information that may conflict with other reported Member information. For example: If a Program Code does not match a Foster Care indicator then the Program Code value should be populated.
DataElement#2	Member information that may conflict with other reported Member information. To follow the example from Data Element #1: If a Program Code does not match a Foster Care indicator then the Foster Care Indicator should be populated.
DataElement#3	Member information that may conflict with other reported Member information.
DataElement#4	Member information that may conflict with other reported Member information.
MCO Comments	When the activity was identified through a HIPAA 834 transaction the HIPAA 834 transaction date is to be included as the first comment. Other comments may be included when the MCO believes it will assist the DMS in review of the report.
Action	The research results reported by DMS.
Action Date	The date the DMS reviewer reviewed and, if necessary, modified the Member's Information.
DMS Comments	Description of the reason why the "Action" was taken.

Report#:	220	Created:	03/31/2012
Name:	Newborn	Last Revised:	
Group:	HIPAA 834 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:			
Due Date:	15th of the Month		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The MCO shall submit the 'Newborn' report (MCO Report # 220) monthly for all newborns that are thirty (30) days or older for which the MCO has not received a HIPAA 834 enrollment transaction.

**Sample Layout:**

THIS SECTION TO BE COMPLETED BY THE MCO										TO BE COMPLETED BY DMS				
#	Newborn Last Name	Newborn First Name	Date of Birth	Gender	Newborn County	Mother's Member Number or SSN	Mother's Last Name	Mother's First Name	Days Old	Action	Action Date	30 Day Action	30 Day Action Date	Comments
1														
2														
3														
4														

**Reporting Criteria:**

General Specifications	Definition
Date Format	All report dates are to be in the following format: mm/dd/yyyy unless otherwise stated.

Row Label	Description
NA	NA

Column Label	Description
#	Counter to easily identify record.
Newborn Last Name	The Newborn's last name.
Newborn First Name	The Newborn's first name.
Date of Birth	The Newborn's date of birth.
Gender	The Newborn's gender.
Newborn County	The three digit county code of the Newborn to be reported as a 3 character text string.
Mother's Member Number or SSN	Provide Newborn Mother's Medicaid ID or Social Security Number associated with the mother's enrollment information from the state system.  Medicaid ID to be reported as a text string. SSN to be reported as a 9 character text string without any dashes.
Mother's Last Name	Provide Newborn's Mother last name if available at time of the report associated with the mother's enrollment information from the state system.

Mother'sFirst Name	Provide Newborn's Mother first name if available at time of the report associated with the mother's enrollment information from the state system.
Days Old	Provide Newborn's age as number of days old. The Newborn on their date of birth is to be counted as one (1) day old.
Action	The research results reported by DMS. Valid values and their description are:  NNE: The Newborn is not enrolled in Medicaid. Enrollment process has been initiated.  NE not MCO: The Newborn is enrolled in Medicaid but is not eligible for enrollment in the MCO.  NE MCO: The Newborn is enrolled in Medicaid and is enrolled with the MCO.  NE add MCO The Newborn is enrolled in Medicaid and has now been assigned to the MCO.
Action Date	The date the DMS reviewer initially reviewed the Newborns Medicaid eligibility and, if necessary, assigned the Newborn to the MCO. It is not the date of enrollment. Rather it is the date that MCAPS and/or MMIS were updated with the assignment.
30 Day Action	For 'Action' values of NNE, DMS will update the status of the Newborn Medicaid enrollment. Valid values and their description of that action are:  NE and MCO: The Newborn was enrolled in Medicaid and assigned to the MCO.  NE not MCO: The Newborn was enrolled in Medicaid but was not assigned to the MCO.  NNE: The Newborn was not enrolled in Medicaid.
30 Day Action Date	The date the DMS reviewer updated the Newborn Medicaid Enrollment and, if necessary, assigned the Newborn to the MCO. It is not the date of enrollment. Rather it is the date that MCAPS and/or MMIS were updated with the assignment.
Comments	Description of the reason why the 'Action' and/or '30 Day Action' was taken. The Newborn Medicaid Id will be provided For Newborns enrolled in Medicaid that are assigned to the MCO ('30 Day Action' value of NE and MCO).

Report#:	230	Created:	03/31/2012
Name:	Capitation Payment Request	Last Revised:	
Group:	HIPAA 820 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	Months prior to or equal to the MMIS Reconciliation Month		
Due Date:	45 Days after receipt of the HIPAA 820 containing the MMIS Reconciliation Month		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The MCO shall submit the 'Capitation Payment Request' report of all members that the MCO identifies for which payment has not been received. Only those months equal to or prior to the MMIS Managed Care Reconciliation Month (MMIS Recon Month) are to be reported.

**Sample Layout:**

Instructions for submitting the report are in Appendix P – MCO CAPITATION RECONCILIATION INBOUND/OUTBOUND FILE LAYOUTS

Report#:	250	Created:	03/31/2012
Name:	Capitation Adjustments Request	Last Revised:	
Group:	HIPAA834 Reconciliation Reports	Report Status:	Active
Frequency:	Monthly	Exhibits:	
Period:	Months prior to or equal to the MMIS Reconciliation Month		
Due Date:	45 Days after receipt of the HIPAA 820 containing the MMIS Reconciliation Month		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The MCO shall submit the 'Capitation Adjustment Requests' report for Members that the MCO believes an inaccurate capitation payment was made. The capitation adjustment requests are limited to the capitation payments made for the MMIS Recon Month or capitation payments that were made as retroactive payments that will not be adjusted through the MMIS Recon processes because the capitation month is prior to the MMIS Recon Month.

**Sample Layout:**

Instructions for submitting the report are in Appendix P – MCO CAPITATION RECONCILIATION INBOUND/OUTBOUND FILE LAYOUTS

Report#:	251	Created:	04/10/2018
Name:	Provider Credentialing Status Report	Last Revised:	06/11/18
Group:	Provider Enrollment	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

This report documents the status of all providers by Medicaid Provider Type with the activity related to Provider Credentialing and Enrollments of Providers by the MCO Providers who have applied for credentialing/enrollment in multiple Provider Types are to be reported under each Provider Type.

**Sample Layout:**

MCO Provider Enrollment and Credentialing							
NPI	Last/Entity Name	First Name	Provider Type	Provider Type Description	Date Credentialing Process Initiated by Provider	Current Status	Explanation

**Criteria**

General Specifications	Definition
Date format	All dates are to be in the following format : mm/dd/yyyy
Sorting	The report should be sorted by "Date" with the oldest entry first.

Column Label	Description
NPI	The Provider's NPI
Last/Entity Name	For an individual, report the last name of the Provider; for a Provider Group/Entity, report the Group/Entity Name
First Name	The Provider's first name
Provider Type	Provider Type Code based on Kentucky's recognized Provider Types
Provider Type Description	Description for Provider Type
Date Credentialing Process Initiated by Provider	The date credentialing process initiated by provider is the Receipt Date that the MCO receives the enrollment form from the Provider
Current Status	The status of the Provider's application. Entries may include, but are not limited to, Approved, Closed, Denied, In Process, Pending, Holding for Corrections, Returned to the Provider-Corrections, Returned to the Provider-Already Enrolled, Returned to the Provider-Provider Type Not Available, and Returned to the Provider-Application Withdrawn.
Explanation	Short description of the Status

Report#:	252	Created:	05/18/2018
Name:	IMD Report Institution for Mental Diseases 15 Days	Last Revised:	
Group:	Other Activities	Report Status:	Active
Frequency:	Monthly	Exhibits:	NA
Period:	First day of month through the last day of the month.		
Due Date:	By the 15 <sup>th</sup> of the month following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

This report documents the status of all MCO recipients who have been admitted to IMD that Exceeds 15 Days and all recipients who have been admitted to IMD 15 Days or Under.

**Sample Layout:**

IMD Report Exceeds 15 Days

Name of Recipient	Medicaid ID	Facility 1	Admit Date	Discharge Date	Number of Days PER CALENDAR MONTH that are over 15	Comments

IMD Report 15 Days or Under

Name of Recipient	Medicaid ID	Facility 1	Admit Date	Discharge Date	Number of Days PER CALENDAR MONTH that are 15 Days or Under	Comments

**Reporting Criteria:**

General Specifications	Definition
Date format	All dates are to be in the following format : mm/dd/yyyy
Sorting	The report should be sorted by "Date" with the oldest entry first.

Column Label	Description
Member Name	The name of the Medicaid member. Concatenate the Member's <Last Name>, <First Name> <Middle Initial>
Medicaid Member ID	Member's Medicaid ID reported as a text string.
Facility 1	Facility Name
Admit Date	Date the member was admitted to IMD
Discharge Date	Date the member was discharged from IMD
Number of Days PER CALENDAR MONTH that are over 15	Total Number of Days PER CALENDAR MONTH that member was in IMD that are over 15
Number of Days PER CALENDAR MONTH that are 15 Days or Under	Total Number of Days PER CALENDAR MONTH that member was in IMD that are 15 Days or Under
Comments	Additional Comments

Report#:	253	Created:	04/11/2019
Name:	Substance Use Disorder (SUD) Inpatient and Residential Treatment	Last Revised:	06/08/2020
Group:	Other Activities	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

#### Description:

This report documents the status of all MCO recipients who have been admitted to an Inpatient and/or residential treatment facility for Substance Use Disorder (SUD) treatment. Reporting the days for this inpatient/residential treatment for SUD will be from paid claims for the service.

#### Sample Layout:

Medicaid Member ID	Provider Name/ Provider Number	Provider Type	Facility Name if Different from Provider Name	Facility Physical Address if Different from the Provider Address	Admit Date	Discharge Date	Discharge Status	Total number of days per single admission	Comments


#### Reporting Criteria:

General Specifications	Definition
Date format	All dates are to be in the following format : mm/dd/yyyy
Sorting	The report should be sorted by "Date" with the oldest entry first.

Column Label	Description
Medicaid Member ID	Member's Medicaid ID reported as a text string.
Provider Number and Provider Name	Medicaid ID assigned by the Department and Provider name associated with the Provider Medicaid ID as listed in MMIS
Provider Type	Provider Type provider is enrolled with Medicaid
Facility Name if different from Provider Name	Facility Name if different from Provider Name. Several Facilities can be listed under one Provider Number and Provider Name.
Facility Physical Address if Different from Provider Address	The Physical address of Facility if Different from Provider Address
Admit Date	Date of single admission. If member has a second admission in the same month it will be inputted as a second admission.
Discharge Status	Where member is referred to for follow up lower level treatment.
Discharge Date	Date the member was discharged from inpatient/residential SUD treatment.
Number of days per single admission	Total Number of Days per single admission per calendar month.
Comments	Additional Comments

Report#:	300	Created:	04/12/2019
Name:	Quarterly LRC Report	Last Revised:	
Group:	Financial	Report Status:	Active
Frequency:	Quarterly	Exhibits:	D, E, F
Period:	First day of quarter through the last day of quarter.		
Due Date:	30 calendar days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

#### Description:

The Quarterly Benefit Payments report provides MCO financial activity for the Medicaid and Kentucky Children's Health Insurance Program (KCHIP) by MCO Quarterly Months and State Category of Service; Monthly Eligibles: Average Monthly Cost per Eligible Report only includes financial activity related to Benefits including claims, claim adjustments, mass adjustments, sub-capitation, and other financial payments/recoupment activity not processed as part of claims activity. Categories of Service are grouped by Medicaid Mandatory and Medicaid

Optional Services. Criteria to properly identify and report EPSDT services and KCHIP services are to be applied as outlined below.

List Amount withheld to meet DOI Reserve Requirements and List Any Distribution of Moneys Received or Retained in Excess of these Reserve Requirements

List 12-Month Averages Medicaid (non KCHIP) and list 12-Month Averages KCHIP on the last Quarter of the year. This report will start in July and end in June. Report 1<sup>st</sup> Quarter July, August, September, 2<sup>nd</sup> Quarter October, November, December, 3<sup>rd</sup> Quarter January, February, March, 4<sup>th</sup> Quarter April, May, June. The 4<sup>th</sup> quarter report ending in June-List the 12-Month Averages for Medicaid (non KCHIP) and list the 12-Month Averages KCHIP.

#### Sample Layout:

MCO Data for LRC Quarterly Report						
Medicaid (non KCHIP) - All Regions						
COS	COS Description	mm/yyyy	mm/yyyy	mm/yyyy	Qtr. Total	Monthly Eligibles
						Average Monthly Cost per Eligibles
						12-Month Averages
						mm/yyyy
						mm/yyyy
Medicaid Mandatory Services						
02	Inpatient Hospital					\$0.00
12	Outpatient Hospital					\$0.00
	Subtotal: Mandatory Services	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Medicaid Optional Services						
03	Mental Hospital					\$0.00
04	Renal Dialysis Clinic					\$0.00
	Subtotal: Optional Services	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Total: Mandatory and Optional Services		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
	Reinsurance					\$0.00
	Pharmacy Rebates					\$0.00
Amount withheld to meet DOI Reserve Requirements						\$0.00
Any Distribution of Moneys Received or Retained in Excess of these Reserve Requirements						\$0.00
Grand Total		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

MCO Data for LRC Quarterly Report

KCHIP - All Regions

COS	COSDescription	mm/yyyy	mm/yyyy	mm/yyyy	Qtr.Total	Monthly Eligibles	Average Monthly Cost per Eligible	12-Month Averages
						mm/yyyy	mm/yyyy	

#### Medicaid Mandatory Services

02	InpatientHospital				\$0.00
12	OutpatientHospital				\$0.00
	Subtotal: MandatoryServices	\$0.00	\$0.00	\$0.00	\$0.00

#### MedicaidOptionalServices

03	MentalHospital				\$0.00
04	Renal Dialysis Clinic				\$0.00
	Subtotal: Optional Services	\$0.00	\$0.00	\$0.00	\$0.00

Total: Mandatory and Optional Services	\$0.00	\$0.00	\$0.00	\$0.00
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Reinsurance				\$0.00
Pharmacy Rebates				\$0.00
Amount withheld to meet DOI Reserve Requirements				\$0.00
Any Distribution of Moneys Received or Retained in Excess of these Reserve Requirements				\$0.00

Grand Total	\$0.00	\$0.00	\$0.00	\$0.00
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#### Reporting Criteria:

General Specifications	Definition
Financial Activity	Payments reported are to be based on date of payment.
EPSDT Services	Multiple Provider Types may provide EPSDT services. Reference Exhibit E for EPSDT Category of Service crosswalk for additional information regarding the identification of EPSDT services.
DateFormat	All report dates unless otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
Subtotal: Mandatory Services	Calculated Field: Total for all mandatory category of services listed in the report.
Subtotal: Optional Services	Calculated Field: Total for all optional category of services listed in the report.
Total: Mandatory and Optional Services	Calculated Field: Total of 'Subtotal: Mandatory Services' and 'Subtotal: Optional Services'.
Reinsurance	MCO premium payments for stop-loss insurance coverage.
Pharmacy Rebates	Drug Rebates collected by the MCO. 'Pharmacy Rebates' is to be reported as a negative value. Note: The state is responsible for collecting federal drug rebates.
Amount withheld to meet DOI Reserve Requirements	The amount of money withheld to meet DOI Reserve Requirements
Any Distribution of Moneys Received or Retained in Excess of these Reserve Requirements	The amount of money Received or Retained in Excess of these Reserve Requirements
Grand Total	Calculated Field: Total of 'Total: Mandatory and Optional Services', 'Reinsurance' and 'Pharmacy Rebates'.

Column Label	Description
COS	Category of Service: State specific identification of services primarily identified by use of Provider Type. Reference Exhibit D for Category of Service crosswalk.
COSDescription	Description for 'COS'

Medicaid (non-KCHIP)	<p>The Medicaid population services are to be reported separately from the KCHIP population services. Populations to be included are based on the Medicaid Eligibility Groups (MEGs):</p> <ol style="list-style-type: none"> <li>Dual Medicare and Medicaid</li> <li>SSI Adults, SSI Children and Foster Care</li> <li>Children 18 and Under</li> <li>Adults Over 18</li> </ol> <p>Reference Exhibit F for the Medicaid Eligibility Group crosswalk.</p>
KCHIP	<p>The Kentucky Children's Health Insurance Program (KCHIP) population services are to be reported separately from the Medicaid population services.</p> <p>Populations to be included are based on the Medicaid Eligibility Groups (MEGs):</p> <ol style="list-style-type: none"> <li>MCHIP</li> <li>SCHIP</li> </ol> <p>Reference Exhibit F for the Medicaid Eligibility Group crosswalk.</p>
Monthly Eligibles	Enter the number of Monthly Eligibles
Average Monthly Cost per Eligible	Enter the Average Monthly Cost per Eligible
12-Month Averages Medicaid (non KCHIP)	Enter 12-Month Averages Medicaid (non KCHIP) on the 4 <sup>th</sup> Quarter Report ending in June.
12-Month Averages KCHIP	Enter 12-Month Averages KCHIP on the 4 <sup>th</sup> Quarter Report ending in June.

Report #:	301	Created:	07/29/2020
Name:	Targeted Case Management Services	Last Revised:	
Group:	Disease and Case Management	Report Status:	Active
Frequency:	Quarterly	Exhibits:	NA
Period:	First day of quarter through the last day of the quarter.		
Due Date:	30 days following the report period.		
Submit To:	Kentucky Department for Medicaid Services		

**Description:**

The Targeted Case Management Services report lists the Number of Active targeted case management Members and Number of Assessments and Re-assessments Conducted and Evidence of Plan of Care Meeting at least quarterly by population (Severe Emotional Disability Modifier SED - UA, Severe Mental Illness SMI – HE, Substance Use Disorder SUD – HF, and SMI or SUD AND Chronic or complex physical health issue – TG).

**Sample Layout:**

Provider Type and Description	Name of Provider	Number of Active Targeted Case Management Members				Number of Assessments Conducted				Number of Re-assessments Conducted				Evidence of Plan of Care Meeting at least Quarterly by Population			
		mm/yy yy	mm/yy yy	mm/yy yy	Qtr · Total	mm/yy yy	mm/yy yy	mm/yy yy	Qtr · Total	mm/yy yy	mm/yy yy	mm/yy yy	Qtr · Total	mm/yy yy	mm/yy yy	mm/yy yy	Qtr · Total

Reporting Criteria:

Terminology	Definition
Date Format	All report dates not otherwise specified are to be in the following format: mm/dd/yyyy

Row Label	Description
NA	NA

Column Label	Description
Provider Type and Description	Provider Type Code based on Kentucky's recognized Provider Types. Description for Provider Type
Provider Name	Individual Provider list First and Last name; Provider Group list the Provider Group name. Provider name associated with the Provider Medicaid ID as listed in MMIS
Number of Active Targeted Case Management Members	Provide the total Number of Active Targeted Case Management Members
Number of Assessments Conducted	Provide the total Number of Assessments Conducted
Number of Re-assessments Conducted	Provide the total Number of Re-assessments Conducted
Evidence of Plan of Care Meeting at least Quarterly by Population	List Evidence of Plan of Care Meeting at least Quarterly by Population (Severe Emotional Disability Modifier SED - UA, Severe Mental Illness SMI – HE, Substance Use Disorder SUD – HF, and SMI or SUD AND Chronic or complex physical health issue – TG).

